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**UNDERSTANDING THE EXPERIENCE OF  
OLDER PEOPLE IN ACUTE HEALTH CARE**

**LINDESAY IRVINE**

**A thesis submitted in partial fulfilment of the  
requirements for the degree of  
Doctor of Philosophy**

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## **ABSTRACT**

An interest in older people's experiences of acute care and how they make sense of that experience was the starting point for this thesis. Using the epistemological base of social constructionism the thesis examines the experiences of care older people have within acute health care settings and explores the qualified nurse's experiences of care in relation to older people in the context of acute care.

Thirteen patients and fourteen nurses from one hospital participated, through semi-structured interviews, in the study. Field notes were used to further illuminate the context of the research. Data was coded using an inductive coding approach, followed by a refining of categories through the use of concept mapping. Data analysis was undertaken manually and cross checking undertaken to establish clear findings. Patient's understandings and explanations of their care were identified, along with the nurse's views and accounts of care within an organisational context. Many factors were found to be influential in the older person's experience of care. Media coverage of care experiences, along with comparison of personal experiences affected the older person's view of their care experience. The impact of the organisational approach to acute care was seen as a major factor in the care experience from the patient and nurse perspective. Lack of a shared philosophy of care within the nurse population led to a lack of continuity and consistency of care for patients. Similarly differing perspectives on the nature of the patient – nurse relationship led to tensions within the care environment causing stress and de-motivation in the nurse population that ultimately affected the patient experience. A conceptual framework was developed that illustrated the complicity between patients and nurses to maintain the illusion of a caring nurse.

## **CHAPTER ONE**

### **OLDER PEOPLE'S EXPERIENCES OF CARE – AN INTRODUCTION**

The influence of the patient's own life experiences and beliefs on their approach to being a recipient of acute care, and the effects this has on their recovery have always been a continuing source of concern. Initially this interest developed during several years working with older people in the health care sector and continued as the trend of demographics led to an increasing older, but healthier population who would require acute health care services. (Scottish Executive 2005a, Scottish Executive 2006)

Demographic trends (Scottish Executive 2001, Scottish Executive 2005b, Scottish Executive 2006, Registrar General for Scotland 2004) indicate an increasingly ageing population that may place an extra demand on the resource of health care; thus the health care of older people is currently high on the political agenda. Several government and voluntary sector reports have highlighted deficiencies in the care offered to ill older people (Davies et al. 1999, Department of Health 1999, Department of Health 2001b, Health Advisory Service 2000 1998, Department of Health 2001a, Commission for Healthcare Audit and Inspection 2006, Commission for Healthcare Audit and Inspection 2007).

The main themes to emerge from the Health Advisory Service and Department of Health reports are poor physical care environments, physical care that is lacking in quality and staff of limited expertise with deficiency in the fundamental skills of communication. A follow up report in 2006 by the Commission for Healthcare Audit and Inspection suggested that lack of dignity and respect for older people in acute hospitals was a major

area of concern. These Commission for Healthcare Audit and Inspection and Department of Health reports also suggest that nurses in acute care settings neglected the areas of psychological need, understanding of patient biography and did not involve older people in decisions about their care (Commission for Healthcare Audit and Inspection 2006, Commission for Healthcare Audit and Inspection 2007, Department of Health 2001a). For example, it is suggested that current standards of care do not foster independence and self-direction, nor promote dignity and self-respect. Strongly suggested in the reports is the need for further research into therapeutic care of older people (Commission for Healthcare Audit and Inspection 2006, Department of Health 2001b, Redfern 1999, Scottish Executive 2006)

A significant literature exists on various aspects of care of older people in long-term settings (HMSO 1999, Masterton 1997, McCormack and Wright 1999, McCormack 2001) and indeed work in this area has been in existence since Goffman's seminal work on institutionalisation the 1960's.

Some research has explored care of older people in acute settings with an emphasis on the patient experience (Faulkner 2001, Koch et al. 1995, Tolson et al. 1999). Emerging from this work are the themes of depersonalisation, segregation, routinised geriatric care and care deprivation. More recently the notion of empowerment and self-determination within the sphere of the care of older people is an emerging concept (McCormack 2001, Nordgren and Fridlund 2001).

Nurses are the main care providers in acute care settings (Scottish Executive 2000, Scottish Executive 2005c). Research has investigated the broad area of nurses' attitudes



and work in respect of older people (Armstrong-Esther et al. 1989, Pursey and Luker 1995, Reed and Bond 1991, Waters and Luker 1996). Suggestion is made that tensions exist between nurses' personal beliefs, their attitudes regarding older people, the demands made by the organisational context of care and the professional identity imposed by the nurses' perceived roles in that care context. Recent work proposes that there is a balancing and compromising relationship developed between nurses and patients in order to reduce the threat to self integrity caused by organisational demands (Irurita and Williams 2001, Williams 2001a, Williams 2001b). For example, nurses decided on priorities of care by assessing demands from patients, organisational demands and their own needs. If time was limited patients physical needs were given priority over their psychosocial needs and nurse's needs were often neglected. Patients also prioritised their needs in relation to their care, for example, not calling a nurse if they thought they were busy. Adams, Bond and Hale (1998) suggest that the tensions and threats caused by organisational demands can impact on other features of work such as job satisfaction and motivation.

Much of the work in the area of acute care and older people has focussed on the quality of the care provided and the communication elements of care delivery. The effects of hospitalisation on the normally fit and active older person are not addressed. A similar knowledge gap exists in relation to our understanding of how older people in acute care construct their care experiences, and what their expectations of the experience are.

Therefore, this research will:

- Examine the experiences of older people within acute health care settings.

- Examine qualified nurse's experiences in relation to older people, in the context of acute care.
- Locate older people and nurses experiences in the context of two organisational settings

This will generate knowledge leading to a greater understanding of how to deliver more focussed and person-centred nursing care.

By adopting a care approach that recognises the older person's self-concepts, improved recovery rates, reduced lengths of stay and improved perceptions of the quality of care may be achieved.

Similarly, by addressing nurses' perceptions of their experiences in caring for older people in acute settings, ways of reducing role conflict caused by organisational, professional and nursing care demands can be established. The development of a care approach that entails nurses and patients working in partnership towards a common goal should lead to cost-effective care, thus meeting current economic and political climates. Concomitant with this, nurses' job and personal satisfaction could improve leading to increased retention and recruitment of staff.

In Chapter Two a major review of the literature base surrounding the concept of caring in nursing is undertaken to establish the current care context within which nurses in the healthcare sector work. This care context influences the nurse's behaviours and beliefs and thus an understanding of the nature of its effects is important in analysing the care approaches used.

Chapter Three addresses literature on perspectives of care from the patient's and nurse's viewpoints and also literature relating to organisational factors affecting care. This literature informs the development of the research.

### **The literature search strategy**

Literature searches were carried out using a systematic approach and utilised several academic nursing and social science search engines. The Cumulative Index of Nursing and Allied Health Literature (CINAHL) was the main source of materials, although use was made of several others including Applied Social Science Index and Abstracts (ASSIA), British Nursing Index (BNI) and PubMed to capture material that may not have a specific health orientation.

Searches were carried out using the following search terms in the title, abstract, and keywords categories of the search engines: concept of care, nurses' work and older people, patient - nurse relationship, older people and experience of care, patients' perceptions of care, patient self-determination, context of care, nurses' perceptions of care giving, organisation and care.

These initial literature searches were conducted over a span of two years from 2001 to 2003 with follow up searches in 2005 and 2007 to ensure all current and relevant materials were identified and were then revisited after the data collection period to ensure currency and relevance and in order to update and expand the literature base.

This approach was supplemented by the use of snowballing reference sources from within references, and through discussion with selected academic colleagues who were asked for suggestions of good literature in the research area.

Literature that related specifically to older people, nurses, perceptions of nursing care and the organisational contexts of care was included, along with papers that considered other care contexts such as oncology nursing, acute medical and surgical nursing and palliative care. Both qualitative and quantitative papers were included.

Specific exclusions were those papers that were not written in English and would thus require translation, and papers that described research undertaken in care contexts that did not reflect the United Kingdom health care system, for example papers from Malawi and China, as these potentially would not reflect the same cultural aspects of nursing care.

The research approach and its implementation is discussed in Chapter Four, following which Chapters Five to Ten articulating the data analysis are detailed. Chapter Eleven offers a discussion addressing the complexities and interlinking of the patient and nurses experiences in acute care. Finally conclusions and reflections are given in Chapter Twelve.

## **CHAPTER 2**

### **CONCEPTS OF CARING-A LITERATURE REVIEW**

#### **Introduction**

This chapter addresses the literature relating to the concept of caring in nursing. The underpinning conceptual framework of caring in nursing requires to be explored to allow an understanding of the complexities that caring in nursing pose. The literature also offers an understanding of the differing ways caring can be conceptualised by individuals, thus allowing significant aspects of caring to be identified within the research.

The chapter commences with a review of the seminal work by Morse, Solberg et al. (1990), this is followed by exploration of a range, from Radsma (1994) to Stockdale and Warelow (2000), of later academic treatises that develop the concept. Empirical research work on the concept of caring is then reviewed, the challenge to the profession by Paley (2001) is addressed and finally articles post-Paley are reviewed along with a detailed critique of Brilowski and Wendler's (2005) work. No further significant publications addressing the concept of care have been published since 2005. Why this should be is unclear, however, exploration of funding council and research centre projects suggests that the emphasis in research funding is towards developing understanding of the dynamics of ageing through interdisciplinary research (Economic and Social Research Council 2006). In nursing research, areas where there is a poor evidence base for practice and organisational effects on nurses work predominate (Health Services

Research Unit 2006, National Nursing Research Unit 2008, NMAHP Research Unit 2007).

Within this literature review, every effort has been made to return to the primary sources whenever possible to assist in critical and accurate evaluation of the literature being reviewed.

### **Concepts of care**

In the 1980's, various American nurse theorists identified and tried to justify caring as a unique paradigm for nursing. The concept had influenced nursing education, philosophy and research, with a commensurate increasing literature on caring and its implications for nursing practice. Morse, Solberg et al.(1990) challenged the profession by arguing that caring as a concept for nursing was in fact elusive and ill-defined. Morse, Solberg et al.(1990) suggest that examination of the body of literature existing prior to 1990 only increased confusion, with no consensus regarding definitions of caring, components of care or the process of caring. Stating that the articles in the literature on caring in nursing appear repetitive and offer contradictory, differing perspectives, Morse, Solberg et al.(1990) argue that authors neglected to analyse different meanings and perspectives in relation to the term 'caring'. There was an assumption, in the literature, that the nursing profession had a 'taken for granted', shared understanding of the concept of care with no discernable difference of meaning between the terms caring, care and nursing care.

Morse, Solberg et al.(1990) suggest that it was imperative that the various perspectives of caring be clarified, if caring was to stay the essence of nursing. In an attempt to

encourage debate, scholarly questioning and clarification of the varying perspectives of caring, Morse, Solberg et al.(1990) undertook a major literature review, receiving sponsorship and support for the work from two national research agencies in the USA.

To establish a comprehensive review of the literature, Morse, Solberg et al.(1990) include all usages of the terms care, caring and nursing care indicating that, ‘from the literature it is difficult to discern the differences between the terms caring, care and nursing care’ (p2), although one of the articles they reviewed Griffin (1983) does attempt to clarify the use of the terms into two main strands. They do not however, state how the articles were selected or initially found, although almost all of their identified articles have the term care or caring in the title, several do not. One can question the rigorousness of their search as by undertaking a PubMed search for the Years 1981 to 1991, several other nurse authors writing about caring were identified (Chapman 1983, Gallman 1985, Wischart 1982).

Morse’s team restricted themselves to reviewing the nursing literature, although no explanation was given for this decision. In doing this, Morse, Solberg et al.(1990) have neglected a whole body of literature; mainly from the philosophical and feminist perspectives which some of their reviewed articles draw upon (Fry 1988, Griffin 1983). Similarly, reliance on purely the nursing literature implies that nurses have a monopoly on caring and ignores the fact that many other professions; such as social work, allied health professions and doctors, also have a caring role. Morse, Solberg et al.(1990) selection of only nursing literature may result from their desire to claim caring as a

central and pre-eminent role in nursing with other professions' roles in caring being, by inference, peripheral.

It is important to note that the majority (20) of the literature reviewed appeared American in origin. Indeed, six of their selected authors (Aamodt 1984, Bevis 1981, Gardner and Wheeler 1981, Ray 1984, Swanson-Kauffman 1988, Weiss 1988) are contributors within books edited by another of their selected authors; Leininger. This could indicate a certain bias of approach to the concept of caring as these authors may have been selected for the books by dint of their conceptualisation of caring. Other literature seemed to emanate from Canada (Forrest 1989, Gendron 1988, Roach 1987) and the United Kingdom (UK) (Griffin 1983, McFarlane 1976), although it was not possible to locate all the primary sources used in the analysis by Morse, Solberg et al.(1990) in order to verify this. One suggests this reliance on North American literature might be because Morse, Solberg et al.(1990) were taking an insular view of the topic of caring, or possibly they were unable to locate or access nursing literature on caring from elsewhere.

However, on undertaking an extensive literature search using PubMed and CINAHL no nursing literature relating to the concept of caring has been identified prior to 1976. The two UK articles (Griffin 1983, McFarlane 1976) referred to by Morse, Solberg et al.(1990) appear to be the first non-American writings, and Leininger (1981) and Watson (1985) the first authors in America.

Stating that thirty five authors were identified as having definitions of caring, Morse, Solberg et al.(1990) establish the main characteristics of these perspectives through content analysis. The 35 authors used are not named in the text and detailed reference is



made to only 25 authors from this point onwards in the work, although 26 authors (Aamodt 1984, Benner 1991, Bevis 1981, Brody 1988, Brown 1986, Cronin and Harrison 1988, Fanslow 1987, Forrest 1989, Fry 1988, Gadow 1985, Gardner and Wheeler 1981, Gaut 1983, Gendron 1988, Griffin 1983, Horner 1988, Knowlden 1988, Larson 1987, Leininger 1984, McFarlane 1976, Orem 1985, Ray 1984, Roach 1987, Stevenson 1990, Swanson-Kauffman 1988, Watson 1985, Weiss 1988) are listed in the diagram in Morse, Solberg et al's paper. No reference is made to the other 10 authors work or why it was excluded. Through cross-referencing and analysis of the reference list it was possible to identify 12 excluded authors whose titles met the criteria of having care, caring or nursing care in them (Drew 1986, Hernandez 1988, Kahn and Steeves 1988, Kitson 1987, Mayer 1986, Paternoster 1988, Peterson 1985, Poulin 1987, Reverby 1987, Riemen 1986, Wolf 1986, Dunlop 1986).

Review of the primary sources of Dunlop (1986), Reverby (1987) and Kitson (1987) revealed that all three focus on the links between caring, lay-caring and the feminist tradition of nursing. Dunlop (1986) in particular is highly challenging of the idea of defining the concept of caring for nursing stating

*'a more powerful and public statement of caring can be of assistance but is not in itself sufficient' (p669.)*

Similarly Kitson (1987) clearly articulates that lay caring and professional caring share the same main attributes, with Reverby (1987) noting that the historical feminist base of nursing means that the nursing professions assertion of rights to allow it autonomy are drowned out by stronger more powerful groups within health care. All three of these

authors' views do not accord with the attempt by Morse, Solberg et al.(1990) to clarify the concept of caring for nursing; and thus may have been excluded for this reason.

Riemen (1986) undertook qualitative research on patients' views of non-caring behaviours in nursing, a diametrically opposed perspective, which again may have led to its exclusion from the analysis. Access to all 12 primary sources was not achieved but if all were either opposed to the concept of caring or unable to be categorised this might account for their exclusion, and one suggests that whatever the reason Morse, Solberg et al.(1990) failed to review 12 significant articles.

To achieve their categorisation, Morse, Solberg et al.(1990) use the following approach. Content analysis was undertaken allowing the development of five perspectives of care. If the definition of caring was not explicitly defined, Morse, Solberg et al.(1990) identified and classified the theoretical perspective by examining the author's research approach and its underlying assumptions. Each of the 5 perspectives was then allocated a category of caring. These categories were: caring as a human trait, caring as a moral imperative (or ideal), caring as an affect, caring as an interpersonal relationship and finally, caring as a therapeutic intervention. A category was then allocated based on each author's epistemological perspective. It is not stated how the research team came to a consensus of decision regarding the category allocation, making it difficult to establish the veracity and rigour of the allocation process. An example is given of how the underlying assumptions were used to categorise work. Two authors, (Aamodt 1984, Stevenson 1990) allude to nurse behaviours that denote care, thus they are categorised into the Therapeutic Intervention category. If the conceptualisation of caring was

described by authors as a process, linear linkages between the categories were indicated on the diagram developed by Morse, Solberg et al.(1990) (See Appendix A)

As an example of this, Morse, Solberg et al.(1990) use Forrest (1989), who, they argue, does not view caring as a process but only as an affect. This decision is hard to justify as the author of this primary source quite clearly aligns the results of their phenomenological study with Roach (1987), who has been allocated the Human Trait category. Similarly, Forrest (1989) makes clear reference to the link between nurses empathetic involvement (affect) and the importance of interpersonal interactions between nurses, patients and their families. This would indicate linkage between categories, and thus caring being seen as a process, but this is not identified or acknowledged by Morse, Solberg et al.(1990).

A second example offered by Morse, Solberg et al.(1990) is Leininger (1984), with an allocation to the human trait categorisation because Leininger (1984) reiterates that humans are caring beings, and caring a universal trait. However, this time, Morse, Solberg et al.(1990) suggest there is an explicit link to Therapeutic Intervention category, as Leininger (1984) identifies behavioural attributes of caring. Thus simple categorisation is difficult as there are overlaps, however, Morse, Solberg et al.(1990) do not comment on this. Scrutiny of this allocation and linkage process which has identified these issues leads one to suggest that the rigour and veracity of the allocation decisions is not as robust as suggested by Morse, Solberg et al.(1990).

Finally, in describing the process of allocating categories, Morse, Solberg et al.(1990) prevaricate about their decisions by stating

'categories are not intended as rigid or inflexible cells, nor is any value judgement intended as to the appropriateness or inappropriateness of the derivations of the categorisations. They are merely identified to clarify aspects inherent in the complexity of the literature rather than to imply causal relationships.' p2/3

They suggest that many of the linkages are tenuous, have been inferred and thus they need further development. With this caveat in mind it is important to briefly discuss each category in turn.

### **Caring as a Human Trait**

Using the diagram (Appendix A), seven authors are identified (Benner and Wrubel 1989, Fry 1988, Griffin 1983, Leininger 1984, Orem 1985, Ray 1984, Roach 1987), as classifying caring as an innate and essential aspect of being human, but suggest the ability to care as a human being is not uniform and are allocated to this category. Griffin (1983) suggests a giver of care must be able to move from self-centredness to being aware of another's needs. Roach (1987)(cited by Morse, Solberg et al.(1990)) also suggests care can be influenced by one's own experiences of being cared for and expressing caring. Morse, Solberg et al.(1990) note that to date no research had tested these relationships to verify the ideas. Alternatively caring can be culturally derived, as shown by Leininger's (1984) research into trans-cultural caring.

This human caring trait is professionalized and enhanced by the nurses' educational experiences as explored by Orem (1985) and Benner and Wrubel (1989) with the caring trait remaining the motivator for nursing actions.

An aspect of the lack of rigour in Morse, Solberg et al's (1990) literature review is that Fry (1989) (a philosopher and nurse) is included within this categorisation, but from

reading the primary source is potentially mis-categorised. One notes that Fry (1989) specifically focuses on the moral imperative and development of an ethic of caring. Fry (1989) uses Watson (1985) and Gadow (1985) as evidence for her argument. She briefly mentions the idea of caring as a human emotion but this is not central in her argument. In fact Fry's (1988, 1989) work is discussed by Morse, Solberg et al.(1990) under the next category, that of Caring as a Moral Imperative

### **Caring as a Moral Imperative**

Morse, Solberg et al.(1990) see this perspective of caring not as a set of traits nor as what nurses do, but as a moral ideal of commitment to maintaining and preserving the patient's dignity. Three authors allocated to this category (Brody 1988, Gadow 1985, Watson 1985) have contrasting views of its usefulness in practice. One, Watson (1985) arguing that nurse- patient encounters are approximations of care and that caring remains an unattainable ideal. A fourth author, Fry (1988, 1989) although not allocated to it in the diagram, is also included in this section with Morse, Solberg et al.(1990) identifying a direct quote from Fry's (1988) work as part of their explanation of this perspective although after careful reading of the primary source the quote was not located.

Fry (1989) notes that Watson (1985) and Gadow (1985) posit that caring is a natural state of human existence, thus Morse, Solberg et al.(1990) conclude that although the moral imperative authors take a different epistemological stance from the human trait perspectives, they concur with the human trait authors that caring provides the basis for all nursing actions. At this point in their discussion, Morse, Solberg et al.(1990) take a

conceptual leap, and suggest that the nurse's working environment should support and assist nurses in caring and refer to Reverby's (1987) work, (one of the missing 12 articles) to suggest there is a paradox for nursing in trying to care in a society that does not value caring.

Morse, Solberg et al.(1990) argue that nurses are expected, by society, to care for others as a duty. Nurses could not exercise their right to control their own practice, and the working conditions of the time constrained the opportunity to care. One might argue that as the literature review was undertaken in 1990, this situation could have altered in the intervening 15 years, with nurse's gaining more autonomy in their delivery of patient care.

### **Caring as an Affect**

Four authors (Bevis 1981, Fanslow 1987, Forrest 1989, Gendron 1988) were categorised in Caring as an Affect, where the nature of caring involves emotional, empathetic involvement in the patient's experience. A fifth author is included in the diagram, McFarlane (1976) although Morse, Solberg et al.(1990) allocated this author, not to a category but to a line that indicates implicit linkage between the categories of Affect and Therapeutic Intervention. The lack of explanation given by Morse, Solberg et al.(1990) for this allocation causes one to question whether Morse, Solberg et al.(1990) were unable to categorise this article through use of the research approach and underlying assumptions, and if so why they then introduced it in this different manner. Perhaps Morse, Solberg et al.(1990) mistakenly did not include McFarlane (1976) in the Affect category. One would suggest the primary article fits with the nature of the Affect

category, although this is not strongly stated, as this article is about developing a Charter for Caring under the auspices of the Royal College of Nursing.

Morse, Solberg et al.(1990) synthesise these authors' ideas, suggesting this caring response focuses on increasing emotional involvement with, or empathetic feelings for the patient. Engagement in this process rewards the nurse with feelings of self-worth, respect and personal integrity. Morse, Solberg et al.(1990) summarise Bevis's (1981) developmental stages of attachment, assiduity, intimacy and confirmation. Being developmental, the assumption is made that completion of the first stage occurs prior to the next stage being embarked upon. Non-progression through each stage prevents caring from taking place and instead the activity becomes altered and non- caring. This perspective of caring expects the nurse to act selflessly without gratification or expectation of material reward, Morse, Solberg et al.(1990) alluding to the historical roots of nursing to explain this approach, making it more surprising that they did not attempt to categorise Reverby's (1987) work.

Morse, Solberg et al.(1990) indicate this perspective of care makes a nurse vulnerable to emotional damage, although support and recognition from nurse colleagues can maintain their ability to care and prevent burn-out. Other issues impacting on this caring approach are those that devalue or jeopardise it. Potential culprits suggested by Morse, Solberg et al.(1990) are constraints on time, technological demands and unattractive patient characteristics along with the institution offering no incentive to nurses to care in this manner.

Additionally, Morse, Solberg et al.(1990) argue that further erosion of this category is caused by the effect of professional socialisation of nurses that expects them to remain

objective and not become involved with the patients. One can argue, however, that this aspect of professionalism in nursing has less emphasis placed upon it in the current educational and clinical development of nurses. Therefore, it may no longer be a factor in preventing the development of this aspect of caring. An opportunity exists to explore this, through the thesis, with nurse's gaining more autonomy in their delivery of patient care.

### **Caring as Interpersonal Interaction.**

Caring as interpersonal interaction is the fourth category defined by Morse, Solberg et al.(1990); although they discuss it under the heading of caring as the nurse-patient interpersonal relationship within the text. This category encompasses work by four authors (Gardner and Wheeler 1981, Horner 1988, Knowlden 1988, Weiss 1988) The inclusion of Gardner and Wheeler has to be postulated as, in the diagram, the initial (G) used to identify the authors is the same as that for Gadow (1985) who is included in Caring as a Moral Imperative. However, by cross-referencing to the list of authors provided with the diagram, Gardner and Wheeler (1981) should be indicated by GW and this does not appear anywhere on the diagram. Textual reference is made to Gardner and Wheeler's (1981) work for this category so one has to assume these authors fit in this category. Omission of the letter W in the abbreviations in the diagram leads one again to question the rigour of the work, although it may be a typographical error.

Morse, Solberg et al.(1990) suggest that these authors view the nurse-patient relationship as the essence of caring. They argue that this view contrasts with those authors in the previous two categories as the underpinning perspective in this category is that the



essence of caring lies within interactions between nurses and patients. Morse, Solberg et al.(1990) advocate that authors expressing this view believe the interaction between nurse and patient expresses and defines caring, and that caring encompasses feelings and behaviours. How this conclusion is reached is not addressed by Morse, Solberg et al.(1990), and without recourse to all primary sources one can only make judgement using the titles of the selected articles. These article titles suggest that the authors all defined caring from a nursing perspective, and were constructing some form of model to do this. Thus it is difficult, as patient views do not appear to be included, to argue that the interaction between the **patient** and the nurse can express caring, indeed, one might argue that the patient per se should not be expected to express care for the nurse.

The patient's response to the nurse's interaction may, however, indicate some form of gratitude or expression of feelings that allows the nurse to interpret that they have 'cared' for that patient. Morse, Solberg et al.(1990) make no attempt to explore the interaction element of these works giving no reference to culture or context of care, both of which would have an impact on the interaction.

One primary source, Gardner and Wheeler (1981) using critical incident technique, did acknowledge variation in results for different areas of nursing. From this one paper it seems that interpersonal interaction relates to a combination of offering emotional and physical support or social and emotional support depending on the context of care with authors stressing that nurses perceived the emotional element of support as the biggest aspect of their care role. As the synopsis of all the authors works offered by Morse, Solberg et al.(1990) is contained within one paragraph, one can argue that the exposition

of these works is less than clear, appearing to be a linking together of several authors ideas with no cohesive conclusion being drawn about the nature of this category.

A much greater analysis plus conclusion is offered for the other 4 categories. This leads one to question whether this particular category is or can be defined from the literature, or in fact differs from the category of therapeutic intervention.

### **Caring as a Therapeutic Intervention**

The fifth and final category of caring – caring as a therapeutic intervention; is allocated by the researchers, to seven authors (Aamodt 1984, Brown 1986, Cronin and Harrison 1988, Gaut 1983, Larson 1987, Stevenson 1990). Morse, Solberg et al.(1990) suggest these authors link caring directly to nursing interventions, or to the conditions necessary for caring; thus making these authors a group who more directly link caring to actual work of nurses. This work of nurses is not defined by Morse, Solberg et al.(1990), from the literature, therefore, it is unclear whether it includes only the physical or observable work or also the more affective, non- observable aspects of work. Using examples of caring actions such as attentive listening, touch, ‘being there’ and technical competence Morse, Solberg et al.(1990) imply that all aspects of nurses’ work are included, not just those that are observable. Indication is also given by Morse, Solberg et al.(1990) that their selected authors all emphasise the importance of nurses having the knowledge and skills needed to undertake care actions that meet the patient’s needs.

According to Morse, Solberg et al.(1990), several authors,(Aamodt 1984, Brown 1986, Cronin and Harrison 1988, Larson 1987, Mayer 1986); Mayer not being one of their categorised articles, have sought patients’ perceptions of being cared for. Again one

queries why Mayer (1986) has been excluded from the categorisation process, however, the work is a replication of Larson's (1987) study thus it may have been excluded as it reiterates Larson's (1987) results. The previous four categories focussed exclusively on nurse's perceptions, and have in the main been academic treatises, rather than empirical research studies, with a few notable exceptions such as Leininger (1984)(Human trait) and Forrest (1989)(Affect). One might suggest that this overwhelming focus on the nurse's perspective was a result, in the late 1970's and early 1980's, of the profession's attempt to justify through research and scholarly activity, its position as a profession in its own right. One can argue that until nurses understood their own perspective regarding care, those of their patients was seen as of a lesser importance. Similarly, at that time, the emphasis in health care was to regard the patient as a recipient of professionally defined care, rather than an equal partner in the decision- making process. It is questionable whether that situation has in fact altered, and this current research may highlight issues that remain for patients' experiencing acute care.

Identifying that patients' views are used in two ways Morse, Solberg et al.(1990) conclude that Mayer (1986), Larson (1987) and Cronin and Harrison (1988) use patients' views as a means of verifying as 'caring', pre-selected nursing actions rather than to define caring. Review of the primary sources showed that Mayer (1986), Larson (1987) and Cronin and Harrison (1988), used either purely quantitative methods, or quantitative methods such as survey, combined with open-ended questions to elicit patient responses and undertook statistical analysis of the results. By doing this the nature of defining caring remained in the hands of the nurses and therefore, it can be argued does not truly represent a patient's perspective of care.

A second set of authors; Aamodt (1984) and Swanson-Kaufmann (1988), who are categorised in Morse, Solberg et al.'s (1990) analysis, and Drew (1986), Riemen (1986) and Paternoster (1988) who are not included in the categorisation are identified by Morse, Solberg et al.(1990) as focussing on the patients' definitions and components of caring. Morse, Solberg et al.(1990) suggest that *this type of research* (p6), they do not identify which type of research approach is used, enables the researcher to delineate the concept of care, and permits patients to identify nursing interventions that signify caring. One proposes that by *this type of research*, Morse, Solberg et al.(1990) mean research using the patients' views; however this is not made clear in the text.

The second set of authors repeatedly identifies several actions of nurses which are seen as caring by patients. However, they also identify discrepancies between patients' and nurses' perspectives of care, with patients focussing on the instrumental (doing) behaviours and nurses focusing on the expressive (affect) aspects of caring behaviours reflecting the results of Gardner and Wheeler (1981). Morse, Solberg et al.(1990) argue that this incongruence allows credence to be given to establishing and further considering the patient's experiences of care. This will be undertaken in the current research.

Following the discussion of allocation of categories of caring Morse, Solberg et al.(1990) offer a short synopsis of the three existing theories of care developed for nursing. These three theories are propounded by Leininger (1978, 1981, 1984, 1985), Watson (1985) and Orem (1985) and all are categorised in the first part of Morse, Solberg et al. (1990) paper. A critique of each theory is given along with a view of the

theory's usefulness to nursing. Morse, Solberg et al.(1990) focus mainly on Leininger's work, seeing it as ideal for nursing, whereas they conclude that Watson's theory of caring could apply equally to other professionals such as theologians and psychologists who are also involved in caring and therefore, does not offer a unique caring role for nurses. However, one has to note that Morse, Solberg et al.(1990) in making this point regarding Watson's work, fail to acknowledge their lack of literature on caring from out-with nursing in their own article.

The inclusion and relevance of this section to the review is unclear as Morse, Solberg et al.(1990) do not indicate why they have chosen to discuss these theories nor do they link the section to their subsequent discussion. One suggests it has no clear relationship with the overall focus of the discussion in the paper. The inclusion of these three particular theories may be an attempt by Morse, Solberg et al.(1990) to support their desire to make the review as comprehensive as possible, to strengthen their argument regarding the conceptualisation of caring, and to evaluate the applicability of caring to the practice of nursing (p2). However, it may be that Morse, Solberg et al.(1990) felt that, as the research was supported by the National Centre for Nursing Research, USA, and Leininger (1984) and Watson (1985) in particular are considered the major instigators of the work on caring in the USA, they should include a more in depth section on their work as they might have left themselves open to criticism from the funding bodies had they not.

One then questions the inclusion of Orem (1985) in this section, perhaps these three theories have been selected because they have been substantiated through research, but then why not include Benner and Wrubel (1989) who's Primacy of Caring is, by this

reckoning, also a theory. As the authors of these three theories are all included in the literature Morse, Solberg et al.(1990) selected to review, and therefore, their theories are addressed, it remains a moot point why this section is included.

Having established the five categories of caring through review of the literature, Morse, Solberg et al.(1990) then produce a diagrammatic representation of the categories which allowed them to show how most of the twenty five authors linked their primary emphasis of caring with the other defined categories thus illustrating caring, not as a static entity, but as a process that moves between categories.

One notes from the diagram (Appendix A) that 6 explicit links and 8 implicit links are illustrated by Morse, Solberg et al.(1990), who state that most links are ill-defined. However, as Morse, Solberg et al.(1990) were able to identify the links this may be overstating the situation. Morse, Solberg et al.(1990) also suggest the linkages are tenuous and need further development, and therefore it is arguable whether this idea of caring as a process is a view held by the reviewed authors or one imposed by Morse, Solberg et al.(1990). On review of some primary sources, (Forrest 1989, Fry 1988, Fry 1989, Griffin 1983), one can identify where authors have made links, and would, on occasion disagree with Morse, Solberg et al's (1990) identification of some of them as implicit rather than explicit. Using Griffin (1983) as an example Morse, Solberg et al's (1990) indicate an implied linkage between the Moral imperative and Affect categories. However, Griffin (1983) quite clearly states: 'I shall try then to explore further the cognitive, moral and emotional aspects of caring' (p291) and links them in a coherent way, so contrary to Morse, Solberg et al's (1990) view, the linkage is not implied but explicit.

Although identifying many of the linkages as ill-defined or implicit, Morse, Solberg et al's (1990) still conclude that, through nursing actions and work, an outcome of caring in nursing is a change in the patient's physical and psychological experience.

Using the five categories, and the notion of caring as a process, Morse, Solberg et al (1990) go on to discuss whether caring can be a uniform state or is present in differing degrees within individuals. Data from the 5 different categories is compared with Morse, Solberg et al (1990) suggesting that the Human Trait authors imply nurses should be more caring than non-nurses, and that they show their caring in different ways from lay-carers. They support this by reference to Kitson (1987) and Hernandez (1988) (2 of the missing authors). Similarly they propose that authors in the interpersonal interaction category suggest a caring mode of interaction can be taught and thus variable levels of caring will be shown by nurses depending on their experience and practice. Morse, Solberg et al (1990) also suggest that, using the moral imperative category, nurses' will care for patients with similar needs in an equal way. Advocating that there is still little evidence that caring is a uniform state, Morse, Solberg et al (1990) then explore the affect and therapeutic categories, arguing that burnout from emotional and physical exhaustion may reduce the ability of the nurse to continue providing care. Criticism of researchers is implied at this point, as according to Morse, Solberg et al (1990) they continue to examine caring rather than non-caring encounters.

Having commenced the article by censuring others for a lack of clarity and rigour in their work, Morse, Solberg et al (1990), then introduce an imprecise and non researched element to support their argument. They suggest that, from their own experiences in clinical practice, nurses do not use the same caring approaches with all patients, but alter

the style of interaction (including affect), and approach as they move from patient to patient. No suggestion is made by Morse, Solberg et al (1990) as to how nurses may know how to make this adjustment, whether it is an innate ability, a learned activity or even how it is recognised. This is an aspect of nurse's caring behaviour that may emerge from this thesis.

Morse, Solberg et al (1990) conclude by proposing that delineation of these behaviours and styles of care would be a significant contribution, although to what they do not say, and note that it has yet to be explored.

Additionally to the 5 categories of caring, Morse, Solberg et al (1990) identified from the literature, that the ultimate outcome of caring was to alter patient responses; although they state this is often only implied by the authors. Firstly, authors who are explicit in this (Benner and Wrubel 1989, Bevis 1981, Brown 1986, Cronin and Harrison 1988, Gadow 1985, Swanson-Kauffman 1988, Watson 1985) mainly concentrate on the patient's subjective experience and with the exception of (Leininger 1984, Orem 1985, Stevenson 1990, Watson 1985), ignore the patient's physical response to care. Morse, Solberg et al (1990) question that if the goal is to change patient outcomes why has little attention been given to the patient with most research focussing on the nurse. In particular, Morse, Solberg et al (1990) challenge the authors in the affect category suggesting that the research by Larson (1987) and Cronin and Harrison (1988) on patients' perceptions, showed patients did not value nurses affect and therefore, developing this aspect may be of limited use to nursing. Similarly, Morse, Solberg et al (1990) suggest the therapeutic nature of caring leaves many questions to be answered, particularly from the aspects of nurse over-involvement or the fostering of dependency.



Again, contemporary nurse theorists are challenged by Morse, Solberg et al (1990) for their lack of attention to these aspects.

Finally moving on to review the consequences of caring, Morse, Solberg et al (1990) propose that caring has limited usefulness in meeting patients' needs as it cannot effect a cure. They suggest that whether a cure can be achieved without caring remains to be explored; as research on aspects such as the consequences of caring on health outcomes, and the effectiveness of caring has not been attempted.

Morse, Solberg et al (1990) conclude that their analysis of the concept of caring and the identification of the five categories of caring are important as a means of convincing critics, who have rejected the concept of caring, of its clinical relevance. This is a sweeping statement that one can challenge as Morse, Solberg et al (1990) only identify one critic, Dunlop (1986). From the primary source, Dunlop (1986) does not reject the concept of caring in nursing per se, she just suggests it is unreasonable to claim nursing as *the* form of caring.

Continuing their conclusion, Morse, Solberg et al (1990) suggest that until a clear conceptualization of caring is established, that includes patient outcomes of caring and all aspects of nursing, progress towards justifying caring as a useful concept for nursing will be restricted leaving caring as an inadequate and partially useful concept for nursing, and state that caring currently does not have the pragmatic implications necessary for the practice of nursing. Noting that none of the authors suggest that caring could be a minor component of nursing, and suggesting that other constructs are a part of caring Morse, Solberg et al (1990) propose that a more encompassing construct, that

has caring as a component, such as comfort, might be more worthy of consideration for nursing.

What is meant by comfort is not defined, nor do Morse, Solberg et al (1990) suggest why it might be a better construct to consider. The profession's response to this challenge has been slight. A PubMed search of the literature has identified only 8 articles published on the concept of comfort in the nursing literature since 1991. Three of these are by Morse, Bottorff et al (1992, 1994, 1995) although no comparison between caring and comfort, nor a definition of comfort is given in these articles; six of the eight articles are from North America. The two non- USA articles are recent publications, Tutton and Seers (2003) in the UK and Williams and Irurita (2005) in Australia. This leads one to suggest that the issue of comfort presents the same challenge of definition and clarity of meaning for nursing as does caring.

A further concern expressed by Morse, Solberg et al (1990) which they call a special concern, is that of the discrepancies that remain between the 5 categorisations. In particular they highlight the conflict between those viewing caring as an interaction, and those viewing it as an intervention. They do not expand or explain this, possibly because of the paucity of their exposition on interpersonal interaction which one has noted could be conflated with therapeutic interventions. Morse, Solberg et al (1990) state that the nurse has to contend with the pull of 'these two divergent concepts of care competing for their allegiance' (p12) not acknowledging that caring may encompass both.

The implication made by Morse, Solberg et al (1990) is that interpersonal interaction, as a supportive activity, requires time for nurses to listen to patients' concerns and that this aspect is not required for therapeutic interventions. They suggest tension can also

develop as administrators look for measurable outcomes, whilst nurses who value caring as an interpersonal interaction want time for less quantifiable tasks that impact on patients' satisfaction. None of these assertions by Morse, Solberg et al (1990) are supported by reference to the literature and one could suggest that Morse, Solberg et al (1990) have another agenda here apart from clarifying the concept of caring. Morse, Solberg et al (1990) conclude that the varying perspectives of care and caring offer an eclectic view of the concept but that these must continue to be debated, along with the inclusion of the patients' perspectives to allow the final concept once it is developed to be applicable to both the art and science of nursing.

Several areas of caring that require further research are identified in the paper and are summarised as follows: the relationship between personal experiences of being cared for and the ability to offer care requires to be tested; the patient's perspective and experiences of care necessitate development, discrepancies between the nurse's and patient's ideas explored, and the different styles of care offered by a nurse to different patients, and when it is offered needs researched.

Morse, Solberg et al (1990) examination of the literature, although lacking in clarity and rigour did obtain its objective of facilitating debate. Many authors since the publication of their work have taken up the challenges they set out.

Following the publication of Morse, Solberg et al (1990), there was an exponential growth of literature relating to the relevance of the concept of caring within nursing. One can assign these publications to varying categories that align with those suggested in Morse, Solberg et al (1990) paper. Some authors continue to attempt concept clarification; others undertake studies that address caring as a moral imperative, several

return to caring as an affect and a further group continue to research therapeutic interventions. It is interesting that one was unable to locate any further literature that would fit the category of caring as interpersonal interaction. There is, however, a growing body of literature that researches the nature of the nurse- patient relationship (Crowe 2000, May 1991, McQueen 2000, Morse 1991) which in itself may indicate that Morse, Solberg et al (1990) title for the category was unclear.

In summary, Morse, Solberg et al (1990) undertook an analysis of the literature on caring based on nursing literature. Although Morse, Solberg et al (1990) stated that previous work on the concept was elusive and ill-defined, one can argue that the evidence suggests that their own analysis was less than rigorous. This is indicated by the lack of explanation regarding the selection of the articles to review and by a lack of clarity in relation to the allocation of authors to categories. By developing categories and the relationships between categories one suggests Morse, Solberg et al (1990) have attempted to oversimplify the concept and do not allow for overlaps between categories. However, several aspects of Morse, Solberg et al's (1990) work, particularly their identification of five categories of caring, allows one to start to develop a framework that will assist in the clarification of caring in nursing.

### **On-going clarification of the concept of caring.**

In the on-going attempts to define caring in nursing one suggests two differing approaches emerge following Morse, Solberg et al's (1990) seminal work. One group of authors continue to attempt definitions of the concept of caring through academic treatise (Kelly 1998, Kyle 1995, Lea and Watson 1996, Mackintosh 2000, McCance et

al. 1997, McCance et al. 1999, Radsma 1994, Sourial 1997, Stockdale and Warelow 2000) and a smaller second group commencing empirical research to try and define the concept (Clarke and Wheeler 1992, Lea et al. 1998, Watson et al. 1999, Yam and Rossiter 2000).

### **Defining the concept of caring through academic treatise.**

Radsma (1994)'s paper aims to consider some of the factors that contribute to the dilemma of care within nursing. Drawing on a similar author base to those in Morse, Solberg et al's (1990) citing authors such as (Dunlop 1986, Leininger 1981, Reverby 1987, Watson 1985) Radsma (1994) develops her discussion, using 13 articles that appear in Morse, Solberg et al's (1990) work, out of a total reference list of 37 articles.

Discussing the issues that contribute to the dilemma of caring in nursing, Radsma (1994) suggests that language and the personal meaning of care has become obscured, with polarities of caring and non-caring being developed. Radsma (1994) argues that the concept of care and terms used to describe it, prevent it from being clearly articulated, using evidence from Dunlop (1986) and Watson (1985) to support her argument. Noting the links between care work, women's work and the vocational nature of care work, Radsma (1994) suggests that care work of nurses, like that of mothers, is essentially invisible and underrated. Continuing this argument Radsma (1994), along with Clifford (1995), identifies the intent and contextual nature of care work, recommending that for care work to achieve its objective it must occur in a supportive environment. With Clifford (1995) suggesting that a formalised caring role for nurses allows them to fulfil a social role in society and allows acknowledgement of the reality of the practice of

caring. Both authors propose that rather than caring being an altruistic ideal which can lead nurses to feel inadequate if they do not achieve it; it be valued and acknowledged, especially by nurses, and this can be achieved through financial reward. Radsma (1994) encourages nurses to define nursing actions – including caring – in economic terms to encourage recognition of the caring ethic in nursing. One has to assume Radsma (1994) is referring to the affective and attitudinal aspects of the caring ethic rather than techno/rational skills as these latter can easily be quantified.

Finally, Radsma (1994) argues that in order to care, the caregiver requires to be cared for within their working environment, and nurses do not often do this for each other, indicating this is indicative of a lack of professional esteem.

Concluding, Radsma (1994) proposes that ‘nursing cannot continue to use the linguistics of care without an explicit and implicit understanding of what professional caring entails’ (p448) and notes that if caring is a nursing value it needs to be embedded into the socialisation of nurses, and the resources to support care behaviours must be available. Although Radsma (1994) identifies several factors that influence the nurse’s ability to care, and Clifford (1995) concludes that it is important that nurses can identify the boundaries of their role and that these definitions match those of the recipients of care, one suggests they do not offer any further clarification of the definition of caring in nursing.

This thesis will allow comparison between the recipients of care’s definitions of care boundaries and experiences, with those of the nurses, to identify whether these are congruent.

### **Literature reviews on caring**

Two literature reviews of the topic followed, Kyle (1995) commences by reiterating that the concept of caring is one of the least understood and defined in nursing practice, and notes the terms nursing and caring are often used interchangeably. The literature surrounding theoretical perspectives is analysed, with Kyle (1995) drawing on many previous authors such as (Dunlop 1986, Fry 1988, Gadow 1985, Gaut 1983, Griffin 1983, Kitson 1987, Leininger 1984, McFarlane 1976, Orem 1985, Watson 1985, Weiss 1988). From these, Kyle (1995) proposes that caring cannot just be considered as a set of behaviours and activities, but that caring is synergistic, and there is more to caring than can be seen. The moral component of caring that contains respect for persons is explored, using authors that appeared in Morse, Solberg et al's (1990) sample of literature namely Gaut (1983), Gadow (1985), Kitson (1987) and Fry (1989). The section is concluded by Kyle (1995) arguing that caring in nursing involves more than a set of activities but also encompasses how the activities are undertaken implying a moral value of respect.

A number of studies on caring in nursing are analysed in the next section, with Kyle (1995) noting that the majority of the studies are quantitative in approach although a few using qualitative methods to explore patient's experiences of care. She also cautions that the majority of articles discussed are from the United States of America (USA), and argues that this makes generalisability difficult because caring varies across cultures, citing Leininger (1981) and Leininger (1984) as evidence.

Commencing with the quantitative research, Kyle (1995) undertakes a detailed description of Larson's (1984) study, then identifies several authors who have gone on to use the same CARE-Q instrument in similar research (Keane et al. 1987, Komorita et al. 1991, Mangold 1991, Mayer 1987, von Essen and Sjoden 1991) although validity of the instrument had been questioned. Kyle (1995) notes the results of these studies were largely similar to Larson's (1984) with nurse's and patient's identifying different 'most important' behaviours. These results, Kyle (1995) indicates, show nurses focussing on psychosocial skills, with patients being more concerned with those demonstrating professional competency. One suggest that this reflects to an extent Morse, Solberg et al's (1990) categories of Caring as Affect for the nurse's results, and Caring as a Therapeutic Intervention on the part of the patients. Interestingly, one notes that in Morse, Solberg et al's (1990) work, patients perceptions only occur in the category of Caring as a Therapeutic Intervention, with Larson (1984) and Mayer (1987) included in their literature sample. Thus one can argue that the continuing evidence from later studies validates Morse, Solberg et al's (1990) category.

Two further quantitative research papers which use inventory instruments to measure caring (Cronin and Harrison 1988, Wolf 1986) are reviewed. Kyle (1995) identifies these as verifying the results from the previous discussed research and therefore concludes that patients perceive professional competence and monitoring of the patient condition as the most important caring behaviours, whereas being asked how they like things done, and what they wish to be called was least important.

The limitations of using quantitative research to explore the concept of caring are highlighted by Kyle (1995), stating that caring is more than a set of behaviours. Kyle



(1995) using Leininger (1984) as evidence, argues the case for an increase in qualitative research to study the concept of caring. Reviewing several qualitative studies (Brown 1986, Drew 1986, Morrison 1991, Paternoster 1988, Riemen 1986), Kyle (1995) suggests that the findings from these studies are comparable; with identified categories of caring that include interpersonal approach, concern for others, attitudes and use of time. She notes that less emphasis on physical care and technical competence is found in the results. Again, one remarks that these areas reflect the categories identified by Morse, Solberg et al's (1990) although this is not commented on by Kyle (1995).

Kyle (1995) concludes the literature review by stating that caring is a complex phenomenon with moral, cognitive and emotional aspects that are culturally defined. Differences between nurses' and patients' perceptions of caring are noted by Kyle (1995) to have implications for nursing practice but these implications are not highlighted. Kyle (1995) further suggests that given the predominance of quantitative research into the topic, further qualitative research should be undertaken to clarify the concept.

Although one can argue that Kyle's (1995) work verifies that of Morse, Solberg et al's (1990) it does not increase the clarity or progress the definition of the concept of care in nursing as Kyle (1995) mainly reiterates the same issues. One notes that out of the 50 articles referred to by Kyle (1995) 26 had previously been cited by Morse, Solberg et al's (1990) in their concept clarification.

A piece of research funded by the National Board for Nursing Midwifery and Health Visiting (Scotland) was undertaken by Lea and Watson (1996) which included a selected review of the literature. Lea and Watson (1996) indicate the review is selective as it

represents the views of the major theorists on the concept of caring, although Lea and Watson (1996) do not indicate who these theorists are. The decision to do a selective review was based on the literature reviews undertaken by Morse, Solberg et al (1990) and Kyle (1995). Lea and Watson (1996) state the aim of the literature review was to look for contrasts between theoretical perspectives, to compare the research methods applied to caring in nursing and to review some of the published research.

Commencing with a historical perspective of the previous 30 years work on the concept of caring, and focussing mainly on the past 20 years, Lea and Watson (1996) identify that several theories have emerged that differ only in the extent to which they see caring as central to nursing.

This difference, suggests Lea and Watson (1996) results in a lack of consensus of the place of caring in nursing, which is compounded by the multiple ways of conceptualising caring. Drawing on Morse, Solberg et al's (1990) work to reiterate the five ways caring can be categorised, Lea and Watson (1996) argue that, along with the dichotomy that exists between theorists, a similar dichotomy occurs in the approach used to researching the topic, with some applying qualitative approaches; although these are not identified by Lea and Watson (1996); and others using quantitative approaches, here Gaut (1983) is cited as an example.

Focusing on the theoretical perspectives, Lea and Watson (1996) select Gaut (1983), Leininger (1984) and Watson (1985) as examples, referring the reader to Morse, Solberg et al's (1990) for detailed review of these theories. In their summary of these theorists Lea and Watson (1996) note that the consequence of Leininger's (1984) and Watson's

(1985) view is that the caring intent of nursing does not change from one patient to another.

Progressing on to reviewing the research into caring, Lea and Watson (1996) argue that qualitative research approaches have assisted in clarifying the concepts within caring and refer the reader to Kyle (1995) for a review of these approaches along with those of quantitative research. However, Lea and Watson (1996) comment that most quantitative researchers did not have adequate sample sizes to allow for appropriate statistical analyses and therefore meaningful conclusions could not be drawn.

Regardless of approach, Lea and Watson (1996) suggest researchers agree that there are several underlying dimensions to caring and again refer to Kyle (1995) for a summary of the findings. One finds this constant referral to another article frustrating, and suggest that if one had not read the primary source of Kyle (1995) much of Lea and Watson's (1996) argument would be unclear.

A summary of the findings of the research into caring is offered by Lea and Watson (1996) by listing varying aspects of research questions along with their authors. They follow this with paragraphs that list authors who identify positive dimensions of caring, and those that include negative dimensions; however, no inferences or conclusions are drawn from these lists. Brief mention is then made by Lea and Watson (1996) of the influence of sex, one assumes here they mean gender, and caring within the nurse curriculum, although no discussion or conclusions are constructed from this. One would suggest that the nature of the funded research, which appeared to be into Scottish nurses and student nurses perceptions of caring, required this inclusion as the funding body was

the National Board for Nursing Midwifery and Health Visiting in Scotland who oversee all nurse education in Scotland.

In summary, Lea and Watson (1996) concur with previous authors that 'caring is a complex phenomenon which lacks a clear definition and which can be conceptualised in a number of ways. Furthermore there is no consensus about the place of caring in nursing' (p 75), and argue that there is a need to reduce caring to its underlying dimensions to understand the structure better. This would require, Lea and Watson (1996) suggest a quantitative method using an adequate sample size, which uses the therapeutic interaction category as its framework. One suggests this conclusion is unsurprising as this is the design of research by Lea, Watson et al.(1998). Further one proposes that Lea and Watson (1996) produced this article, not to advance the discussion and definition of caring in nursing, but rather as a means of generating a paper that would contribute to their respective research writing profiles. The paper does not add anything new to the topic and, in fact, extensively uses Kyle's (1995) work rather than developing ideas and theories of their own. Unsurprisingly, one notes that the bulk of the reference list for Lea and Watson's (1996) paper contains literature identified by Morse, Solberg et al (1990) and Kyle (1995) suggesting that their literature search and review was based around these two reference lists rather than generating their own search.

These two literature reviews, whilst supporting the initial definition of the concept of caring do not progress the discussion and evolution of the concept for nursing, however, it may be that use of concept analysis will.

### **Concept analysis of caring in nursing**

A further academic work by Sourial (1997) undertakes a concept analysis of caring using Walker and Avant's concept analysis approach, indicating immediately that caring has a moral aspect. Sourial (1997) gives no introduction to the article nor any explanation of Walker and Avant's analysis and its application to the literature. As one cannot make any judgement regarding the rigour of the approach the validity of Sourial's (1997) work is reduced.

Sourial (1997) bases her analysis around the five main categories noted by Morse, Solberg et al's (1990) and suggests that caring has a role in enhancing and preserving human dignity with respect being an antecedent to, and a component of caring. Sourial (1997) indicates that moral imperative was one of Morse, Solberg et al's (1990) identified categories of caring, however, no links are made between her concept analysis and Morse, Solberg et al's (1990) work in terms of comparisons or discussion.

By citing Fry (1991) Sourial (1997) links the moral aspect with that of competence which is stated to be another area required of caring. Two dimensions of caring are suggested by Sourial (1997), citing Pepin (1992),— instrumental and affective- examples of these being activities, attitudes and feelings, love and labour, humanistic qualities and scientific actions. At this point one feels Sourial (1997) could have given more depth to the analysis by relating some of these aspects back to Morse, Solberg et al's (1990) five categories of caring. One suggests an example of this would be the linking of the affective dimension with Morse, Solberg et al's (1990) category of Affect. Sourial's (1997) focus is difficult to understand, as the section is about the moral aspect of caring but again using Morse, Solberg et al (1990) as support, Sourial (1997) diverts the

discussion into a debate regarding redressing the balance between affective and instrumental care. One would argue that the evidence used from Morse, Solberg et al (1990) is taken slightly out of context from the main focus of Morse et al's (1990) work, as the evidence used is based on Morse, Solberg et al's (1990) criticism of Watson's (1985) theory that excludes technical and physical aspects of care.

A second section revisits Caring as a Human trait; a category originally defined by Morse, Solberg et al (1990), with Sourial (1997) stating a number of studies use qualitative inductive methods to conclude that patients and nurses views of caring differ although these articles are not identified. One notes this conclusion has previously been made by Kyle (1995) however this work is not referred to by Sourial (1997). As no sampling approach is indicated by Sourial (1997) for the concept analysis, one is unclear as to whether this is an omission, or a result of the sampling technique. Whatever the cause, one suggests a valuable opportunity has been missed for Sourial (1997) to argue this point conclusively.

Sourial (1997) suggests the difference between the patients and nurses views is a result of nurses taking physical care for granted, although no evidence is offered to support this explanation. Sourial (1997) concludes the section on Human Trait by noting that inductive research generates numerous categories of caring, but their influence on nursing theory is unclear.

A description of the literature on holism is then commenced by Sourial (1997) using several authors (Holden 1991, McGuire 1990, Todd 1990) to support this. One has no idea how holism links to the concept analysis of caring or what contribution it makes to the on-going debate. However, by using the definition of holism that relates to

alternative non-traditional Western healthcare, Sourial (1997) argues for the notion of a caring-healing environment using Morse, Solberg et al's (1990) category of Therapeutic Intervention as evidence for this point. Linking holistic medicine to humanistic medicine Sourial (1997) suggests the emphasis is on relationships and personal development of patients and staff rather than treatment. She notes this concurs with Morse, Solberg et al's (1990) categories of Interpersonal Interactions and Affect but again does not draw any conclusions or develop the argument regarding this. Sourial (1997) goes on to suggest the notion of relationship and growth are problematic in institutionalised settings and uses Morrison (1989), Webb (1992) and Keddy (1993) to illustrate why the currently defined nurse – patient relationship of closeness and commitment, is as damaging as the previous detached relationships; concluding as Morse, Solberg et al (1990) previously, that this aspect of caring is impossible to attain.

Although one has no indication of how this links to the concept analysis, Sourial (1997) continues by discussing the issue of caring in bureaucratic systems. She suggests that physical caring may be better facilitated by bureaucratic healthcare systems than affective care and suggests caring goes beyond individual perspectives and requires a broader view.

Questioning how nurses who value caring function within a bureaucratic organisation Sourial (1997) uses Valentine (1989) and Jacques (1993) to support the discussion, suggesting that nurses require to be aware of the structural effects on caring, and to be able to define what caring is to managerial decision-makers. However, one is not clear about where this discussion is leading, or its value in the concept analysis. This lack of focus leaves one unable to draw any substantive ideas from Sourial's (1997) work so far.

Again making no links between this section and previous ones in relation to the concept analysis of caring Sourial (1997) explores patient outcomes of care. She suggests this approach to caring gives a quality assurance focus, citing Morse, Solberg et al (1990), Valentine (1991) and Attree (1993) as indication that some researchers examine the concept of caring through patient outcomes.

One notes that Sourial (1997) gives no indication of how this would work, nor if it would provide valid results thus again wondering about the relationship of this small section to the stated intent of her concept analysis.

Although Sourial (1997) indicates that her analysis identified eight uses for 'caring' from the nursing literature, one argues that these eight uses are not clearly identified in the work and therefore, any potential contribution to defining caring is lost. Further as Sourial (1997) notes these eight uses can equally be claimed by other non nursing professions one wonders what was achieved by her analysis other than a suggestion that the concept of holism is preferable to that of caring. Sourial (1997) argues that holism contains caring and is a more clearly defined and scientifically based concept. One concludes that Sourial's (1997) attempt at concept analysis is less than rigorous as the approach to the process cannot be assessed. One also argues that this concept analysis adds nothing to assisting the on-going clarification of the concept of caring, rather it restates the already known points.

A second concept analysis, using Walker and Avant's (1983) approach, was undertaken by McCance, McKenna et al (1997). In introducing the concept analysis, acknowledgement is given to Morse, Solberg et al's (1990) seminal contribution that revealed five categories of caring. However, arguing that confusion still exists in the



literature McCance, McKenna et al (1997) suggest there is benefit to further exploring the meaning of caring using a concept analysis. Noting that various methods exist for concept analysis, McCance, McKenna et al (1997) justify their selection of Walker and Avant (1983) through its frequent use to analyse concepts related to nursing although they acknowledge that the approach has been criticised as being too linear and positivistic in nature. To ameliorate this criticism, McCance, McKenna et al (1997) incorporate elements of a newer approach by Rodgers (1989) that uses exemplars of cases from the real world rather than the usual hypothetically constructed cases demanded by Walker and Avant's (1983) approach.

Detailed description of Walker and Avant's (1983) approach, including the eight steps of analysis involved, is given by McCance, McKenna et al (1997) with their stated rationale for undertaking a concept analysis as being 'to obtain a clear conceptualisation of caring for the purpose of conducting research and generating theory' (p242). To establish a rigorous approach McCance, McKenna et al (1997) specify details of dictionary and thesaurus use, down to the level of page numbers thus allowing verification of their choices and increasing the validity of their analysis.

McCance, McKenna et al (1997) focus firstly on the nursing literature using well known authors for theoretical definitions (Gaut 1983, Leininger 1981, Leininger 1984, Roach 1987, Watson 1985). Other literature sources are then accessed with McCance, McKenna et al (1997) noting that these sources view caring from perspectives that are consistent with those categorised by Morse, Solberg et al's (1990). As an example McCance, McKenna et al (1997) cite Caring as a Human Trait, which they argue is embedded in existentialistic philosophy, and indeed suggest Roach (1987) and Boykin

and Schoenhofer (1993) have been greatly influenced by this philosophy. One would suggest that it is no surprise then to find these authors identified by Morse, Solberg et al (1990) in the Human Trait category, although this is not commented on by McCance, McKenna et al (1997). Similarly other philosophers, Sartre (1943), Heidegger (1962) and Mayeroff (1971) are also noted to contribute to the notion of care as a mode of being with McCance, McKenna et al (1997) suggesting their term, presence, is often used in the nursing literature to denote authentic being with others.

Moving on to research studies into caring, McCance, McKenna et al (1997) draw on, what one would suggest is now familiar work to illustrate the quantitative methodological approaches (Keane et al. 1987, Larson 1987, Mayer 1986, von Essen and Sjoden 1991), and suggesting that qualitative approaches are more appropriate, citing Leininger (1986) in support of this. McCance, McKenna et al (1997) present the qualitative research authors and their identified themes in two tables: one relating to patient perspectives, the other to nurses' perspectives. One is therefore, able to verify McCance, McKenna et al's (1997) approach and conclusions. Cautioning that these lists are not exhaustive McCance, McKenna et al (1997) suggest they provide a key to the concept of caring. What McCance, McKenna et al (1997) do not do is indicate how these articles were selected and what percentage of the total literature they represent, therefore, one is unable to judge whether they are an adequate representation of the qualitative literature.

Applying Walker and Avant's (1983) fourth step, that of determining the defining attributes of the concept, McCance, McKenna et al (1997) select the meaning of caring most relevant to nursing. This allowed them to identify four characteristics – serious

attention, concern, providing for, and regard, respect or liking; with the suggestion that serious attention is similar to the notion of being present, as indicated by the philosophical sources and Boykin and Schoenhofer (1993). One is puzzled, however, that McCance, McKenna et al (1997) did not reiterate the link to Caring as a Human Trait as identified by Morse, Solberg et al (1990) particularly as they had noted this point earlier.

The characteristic, concern, is justified by McCance, McKenna et al (1997) as it was cited in all the dictionaries, and also as an alternative to care in the thesaurus. However, no evidence from literature is used to support this characteristic, which one suggests is a major limitation in terms of defining care, as one argues that if it does not occur in the nursing literature it may not be a relevant term for caring in nursing. However, one suggests the notion of concern links to the idea of caring as a moral imperative in terms of Morse, Solberg et al's (1990) work and therefore, McCance, McKenna et al (1997) have missed an opportunity to develop this aspect of their characteristic.

Providing for, the third identified characteristic is supported through evidence from dictionaries and common word usage sources. McCance, McKenna et al (1997) also argue that it appears in several definitions of nursing, quoting Henderson's (1966) definition as an example, but no other sources of definitions of nursing are referred to, to allow one to check their assertion.

The final characteristic; regard, respect and liking, is according to McCance, McKenna et al (1997) consistently cited in all the literature sources they examined, although one notes that again these are not stated. They propose that this characteristic focuses on caring as a form of love and indicate several authors hold this view (Bevis 1981, Jacono

1993, Ray 1984). McCance, McKenna et al (1997) argue that for a nurse to love all the patients they care for, never mind like them, is difficult to comprehend in the real world of nursing. However, they suggest respect is a better description of this characteristic, as an individual can be respected as a human being with freedom to choose even if the nurse does not like them.

Steps five and six of Walker and Avant's (1983) analysis are to construct a model and borderline case that illustrate the concept; this accords with Rodgers (1989) approach. McCance, McKenna et al (1997) cite a real world example from Ford (1990) in relation to nurses caring for a cardiac patient and illustrate the where the attributes of caring occur.

Following the model case, a borderline case from Benner and Wrubel (1989) is identified by McCance, McKenna et al (1997) which gives an example of 'not the concept', thus offering a greater understanding of the concept. Again, one notes this is a real world example rather than a constructed one. Explanation is given that they chose the example because there were two critical attributes missing – those of serious attention, and recognising what is important to the patient, in other words respect.

Other case examples such as related cases and contrary cases are noted by McCance, McKenna et al (1997) as also being used to clarify the concept by showing what it is not. Interestingly McCance, McKenna et al (1997) were unable to produce a related case, which is a case closely related to the concept under analysis. Several concepts that might be related, such as compassion, empathy and support, were suggested to them by colleagues, however, McCance, McKenna et al (1997) argue all three can be seen as part of caring and are therefore not separate concepts.

An example of a contrary case – where the case is clearly not the concept was given with McCance, McKenna et al (1997) choosing a case from Riemen's (1986) study on non-caring. One suggests that as Riemen's (1986) work was identifying non-caring behaviours it was self-evident the case chosen would be a contrary case.

Using Walker and Avant's (1983) step seven, McCance, McKenna et al (1997) identify three themes that are antecedents to caring; respect, amount of time and intention to care. However, one is left to assume these as McCance, McKenna et al (1997) only specifically identify 'intention to care' as an antecedent. Several authors are used to support the selection of the third antecedent (Boykin and Schoenhofer 1993, Leininger 1986, Watson 1985).

McCance, McKenna et al (1997) suggest consequences of caring are more difficult to identify but argue that the case studies used highlight the effect caring or non-caring can have on a patient, and thus propose one outcome of caring might be physical and emotional wellbeing.

The final eighth step in the analysis is definition of empirical referents, McCance, McKenna et al (1997) suggesting that often the initial attributes are the empirical referents but that in illusive concepts such as caring, the attributes may be equally vague. This allows McCance, McKenna et al (1997) to highlight the need to examine the concept using qualitative methods of research rather than quantitative methods. One notes this is a reiteration of several previous authors' conclusions (Kyle 1995, Leininger 1984, Radsma 1994).

McCance, McKenna et al (1997) conclude that their concept analysis was a valuable first step in analysing the concept of caring.

One has to disagree with the conclusion, reached by both Sourial (1997) and McCance, McKenna et al (1997), that their concept analysis was a valuable first step in analysing the concept of caring. Many similarities were noted between their work and that of Morse, Solberg et al (1990) although the terminology used was different and therefore, one argues that both Sourial (1997) and McCance, McKenna et al (1997) failed to capitalise on these similarities which would have allowed a clearer definition of the concept to emerge. One suggests however, that the fact that similarities are emerging from the concept should assist in the production of a final definitive concept of caring. These similarities are that caring has four facets (regardless of name allocated by authors) which interact together to produce the concept of caring in nursing. These facets fall into the broad categories identified by Morse, Solberg et al (1990) as moral imperative, human trait, affect and interpersonal interactions.

Kelly (1998) in a further attempt to clarify the concept suggests social science theory provides valuable insights into the caring process. Firstly, Kelly (1998) notes that professional caring is typified mainly by the interpersonal encounters between patient and nurse which allow a number of questions to be explored using psychological perspectives such as motivation to care and coping with the emotional demands of the nurse's role. Using well-known theorists such as Freud (1936), Maslow (1954), Menzies (1975), and Rogers (1990); Kelly (1998) concludes that psychological theory can offer wide ranging insights into the nature of caring in nursing and gives opportunities for research into the topic.

Similarly, sociological and contextual issues of caring as work are discussed by Kelly (1998), using works by several authors (Benner and Wrubel 1989, Goffman 1961, James 1992, Kitson 1987, Larson 1987) to support his discussions. In summary, Kelly (1998) indicates that there are a diverse range of social theories that offer an opportunity to broaden the debate on caring and demonstrate how theoretical constructions of caring need to be more complex in order to reflect the realities of the social work.

Finally exploring the issue of caring as a resource, Kelly (1998) argues that current economic demand places pressure on the nurse to deliver care in a cost controlled environment and these not inconsiderable demands are yet to be sufficiently researched in nursing.

Issues of measuring care, dilemmas in caring and a functional construction of caring are reviewed using models of caring by Valentine (1989) and Seedhouse(1994) which Kelly (1998) notes are useful in stressing that caring is a skill that can be undertaken by the nurse but that until research that either costs or measures care is available as evidence, its importance will not be established.

Kelly (1998) proposes that the theory from social sciences is useful, and bears inclusion into future constructions of caring in nursing as this will encourage more relevant research into the functional role of caring within healthcare. Further benefit would be in clarifying the demands of caring in various real world settings in health-care.

I would argue that Kelly's (1998) work highlights again the issue of the importance of the nurse-patient relationship and this along with the overview of the organisational context add new elements to the concept of caring in nursing that require investigation. This thesis is designed to produce evidence that will add to this knowledge base.

Further work was undertaken by McCance, McKenna et al.(1999) exploring four theories of caring (Boykin and Schoenhofer 1993, Leininger 1985, Roach 1987, Watson 1985) and considering their use in nursing practice. McCance, McKenna et al.(1999) identify that no application of Roach's theory (1987) can be found and suggest this is due to it not previously being considered a theory of nursing. One notes that McCance, McKenna et al.(1999) refer to Roach (1987) as a conceptualisation of caring and do not justify its inclusion as a theory in their work.

Carrying out a comparison of the theories, McCance, McKenna et al.(1999) use identified commonplaces such as origin of the theory, description of caring, description of nursing, key concepts, outcome and scope of theory.

Importantly, one notes that through synthesis of the four theories McCance, McKenna et al.(1999) identify a dual component to caring in nursing. This dual component consists of attitudes and values as one element, and activities as the other. This is the first time, since the commencement of defining the concept of caring, that a new conclusion has been drawn that can be justified. Similarly one suggests that, as with previous authors, McCance, McKenna et al.(1999) clearly identify the value of the nurse – patient relationship, highlighting this relationship as a crucial human element within nursing.

In reviewing the utility of these theories in nursing practice McCance, McKenna et al.(1999) suggest that unless practitioners have an underpinning understanding of the philosophies behind the theories their use in practice is unlikely. The use of a philosophic base to nursing will be explored in the research.



In conclusion McCance, McKenna et al.(1999) propose that all four theories are grounded in a humanistic tradition and that the notion of caring in nursing is thus based on a human science perspective which has influenced the methods used to explore the concept, favouring mainly qualitative methods. One suggests that this conclusion shows that Leininger's (1985) demand for further qualitative research has been met by the profession; with McCance, McKenna et al.(1999) breaking new ground in defining the concept of caring in nursing. Unfortunately they do not, at the end, draw any different or useful conclusions that would assist in defining the concept, although, having identified significant congruence within the four theories, this would enable a definite statement to have been made regarding the concept.

Two further significant papers were published in early 2000 (Mackintosh 2000, Stockdale and Warelow 2000). Mackintosh (2000) explores the assumption that the nursing and caring are symbiotic and interchangeable concepts and argues that this assumption requires reconsideration. Using a broad array of well cited authors; (Bradshaw 1996, Dunlop 1986, Griffin 1983, Kitson 1987, Kyle 1995, Leininger 1981, Leininger 1984, McCance et al. 1997, Morse et al. 1991, Sourial 1997, Warelow 1996, Watson 1985), Mackintosh (2000) discusses the arguments presented and concludes that the nature of care remains highly imprecise leaving nurses in a difficult position as the nurses are unsure of what the care role entails.

One notes that this conclusion has been identified several times before (Kyle 1995, McCance et al. 1997, McCance et al. 1999, Morse et al. 1991, Radsma 1994) to name a

few. So what is occurring is a continuity of argument for the concept of caring with very little innovation or development.

Debating care and nursing, Mackintosh (2000) argues that there is an inherent contradiction in nursing as a caring profession, and the work nurses actually do which often causes discomfort, suggesting this dichotomy is caused by nursing basing itself on scientific knowledge whilst following a humanistic philosophy. Mackintosh (2000) uses several authors (Brown et al. 1992, James 1992, Playle 1995, Salvage 1990, Smith 1991) to support this argument. The issue of relationship, is again, identified by Mackintosh (2000) who suggests that being based on need, the nurse-patient relationship is an unequal one and this presents the nurse with a number of fundamental problems when trying to care. Mackintosh (2000) suggests these problems are; a lack of definition of what caring as a nurse should entail, being in a profession based on conflicting paradigms, and working in an unequal relationship where the needs of the patient and the nurse may conflict. These elements, Mackintosh (2000) argues, prohibit caring in nursing.

Reviewing the effects of socialisation on nurses caring Mackintosh (2000) suggests the process has both positive and negative effects. Citing Melia (1987), Mackintosh (2000) notes that ‘a large part of the socialisation process involves concentrating on the necessity of getting the work done at the cost of any other nurse-patient interaction’ (p324)

One suggests that, given the previous positive emphasis placed on the nurse – patient interaction in terms of caring in nursing, this is a crucial aspect of the patient experience that requires further exploration in this thesis.

Mackintosh's (2000) final argument concerns the notion of caring as a human trait; one of Morse, Solberg et al's (1990) original categories of caring, suggesting that the notion of nurses applying care to all patients indiscriminately as a part of their contractual duties is highly idealistic and places an impossible burden on the nurse.

### **The incongruence of caring in nursing**

Using Menzies (1975) seminal work, along with evidence from Warelow (1996) and Bradshaw (1996) Mackintosh (2000) identifies that in reality nurses erect barriers to shield themselves from the emotional involvement of their role, and potentially become desensitised to patient suffering and suggests this supports the argument that caring is not inherent in the work of nursing. Mackintosh (2000) concludes that caring cannot be synonymous with nursing as it lacks a consistent clearly defined definition with the incongruence between what nurses do in their role and the ethical, moral and affective aspects of the theories of caring in nursing presenting nurses with an insolvable dilemma. Mackintosh (2000) argues that care in nursing should be seen as a component part of a much larger range of nursing skills and abilities, and not the essential essence of nursing. One suggests that this argument involves aspects of economics, workload, organisational theories and socialisation of nurses which has implications for the profession in trying to characterize its role and boundaries within a continually changing health care environment. These aspects of caring will be drawn out in the research.

The final piece of work on caring comes from Stockdale and Warelow (2000) who use a range of dictionary definitions to conclude that the concept of caring cannot be defined,

so suggests that nurses should instead, try to interpret the term through knowing how to use care in practice. Stockdale and Warelow (2000) reiterate the ethical and moral dimensions of caring and also identify the importance of the nurse-patient relationship, drawing on several authors (Brown et al. 1992, Mayeroff 1971, Watson 1985) to support the argument. Discussion of the qualities of caring using the human trait category follows, supported by reference to Watson (1985), Kitson (1987), Leininger (1988b), Fry (1989), Morse, Bottorff et al.(1991), Brown, Kitson et al.(1992) and Kyle (1995); with Stockdale and Warelow (2000) concluding that forms of human behaviour in caring display attributes of commitment, knowledge, skills and respect for person, thus reiterating previous conclusions by other authors.

Revisiting the functions of caring and caring behaviours and attitudes, Stockdale and Warelow (2000) again use authors such as Watson (1985), Leininger (1988b) and Morse, Solberg et al (1990) to argue that the concept of care goes beyond kind thoughts – care has to be demonstrated. Stockdale and Warelow (2000) suggest that whatever a nurse does will have an expressive element to it open to interpretation by a patient as either caring or non-caring.

Stockdale and Warelow (2000) argue that caring is a continuum where most nurses aim to be in the middle, no evidence is offered for this statement and one is not informed how the conclusion is reached. Evidence of the continuum; using Watson's (1985) work of caring as an ideal at one end and Warelow (1996) who suggests caring should be viewed from a patients' perspective, is context dependent and relates to the current circumstances of the situation at the other end, is given by Stockdale and Warelow (2000).

Reflecting on their review, Stockdale and Warelow (2000) note that the scholars they have referred to are all correct but only to a certain degree, with none offering the full picture. One notes, however, that Stockdale and Warelow (2000) do not offer any suggestion to how a full picture might be given, or what the modification might include. Concluding that the philosophy of caring is a worthwhile ideal for nursing; and the nature of caring, its function and expression fit well with daily nursing practices across the world, Stockdale and Warelow (2000) suggest difficulties arise when scholars attempt to argue caring as a superior concept to others and argue that their paper shows that caring cannot be a superior ideal.

One proposes that Stockdale and Warelow's (2000) reiteration of the situation, with regard to caring in nursing, gives a sound overview of the issues raised in the previous academic treatises on the topic. However, again it does not assist in gaining a definitive definition of the concept of caring in nursing although one suggests that Stockdale and Warelow's (2000) proposal to modify the concept may have a value in achieving a definition.

The majority of papers published following Morse, Solberg et al's (1990) work continue the academic debate of the concept of caring in nursing, but with the exception McCance, McKenna et al.(1999) who identify a dual component to caring, few if any expand the underpinning conceptual framework merely maintaining the status quo of five categories of caring (human trait, moral imperative, affect, interpersonal interactions and therapeutic interventions) Morse, Solberg et al (1990). However, more recently empirical research has been undertaken in the areas of Affect, Therapeutic Interventions

and Interpersonal Interactions that further explore these aspects and offer an in-depth insight into these aspects of caring that will inform the data analysis in the research.

### **Research into Caring as Affect**

Three research studies, Staden (1998), Bolton (2000) and Gattuso and Bevan (2000) explore the notion of affect in relation to the concept of caring using qualitative methods as a means of data collection ranging from semi-structured interviews (Bolton 2000, Staden 1998) to focus group discussion (Gattuso and Bevan 2000). All had small sample sizes, which consisted of female nurses. All three researchers commence their articles with discussion of the nature of caring and its relationship to emotional work, using Hochschild's (1983) and James's (1992) work to explore the interrelationship between organisational structures, physical work, emotional labour and caring work. Further Bolton (2000) and Gattuso and Bevan (2000) cite Staden's (1998) work in their discussions.

Staden (1998), Bolton (2000) and Gattuso and Bevan (2000) all record similar findings, although they use different terminologies. The first finding concerned the private/public dimensions of women's caring. This aspect reflects links between dealing with emotional experience at work and at home. Staden's (1998) sample of three nurses indicate that knowledge and techniques of emotional management are a two way process, where experiences and dealing with emotional problems benefits both work and home life. However, all three sample groups identified stressors imposed by the conflict of trying to balance caring with efficiency demands, and difficulties in managing emotions. Bolton (2000) specifically identifies the socialisation effects on nurses to

appear kind and caring but also calm and detached, and suggest 'nurses' skills in emotionally managing potentially awkward or embarrassing situations are a vital part of the caring process' (p583).

A second common theme was coping, although Bolton (2000) labels this as maintaining the professional face. This theme arises from the notion that emotion work is hard work and that it is only when things go wrong or the nurse cannot cope that the product of emotional labour becomes apparent. Nurses in all the sample groups had developed strategies to allow them to cope, either by talking to others and gaining support from peers or by sharing out the demanding patients to others in order to cope.

Value and visibility was the third common theme, with Staden's (1998) study identifying this as its main focus. In all three studies, participants noted they gained great satisfaction from their work and that they valued the emotional caring part of the job, drawing satisfaction from making a difference to patients through the nurse - patient relationship. However, all the studies identified that the nurses doubted whether the organisation placed any value on the emotional input of nurses, and thus the nurses felt alienated from the organisation. One suggests this is due to the difficulties posed by quantifying and measuring the effect of this emotional input and thus organisations are unable to justify the time invested in this aspect of care. This resonates with Mackintosh's (2000) assertion that caring cannot be synonymous with nursing. Staden's (1998) sample also felt their caring work was not valued by society in general. These aspects of caring will be looked at in the research.

Three other themes of ‘giving of self’, appearing caring, and ‘being human too’ appear in Staden’s (1998) and Bolton’s (2000) work. These relate to the expectations and understanding of the general public of nurse’s behaviours and needs in the context of caring.

The three researchers all conclude that caring with emotion work is increasingly under pressure from market driven healthcare, and nurses must demonstrate that caring with emotion work affects patient outcomes positively.

Although these three researchers had small samples and produced non-generalisable results, one can argue that the similarities between the results indicate that Morse, Solberg et al’s (1990) category of Caring as Affect is appropriately defined as one aspect of caring.

### **Research into Caring as a Therapeutic Intervention.**

Four pieces of research, using Morse, Solberg et al’s (1990) category of Therapeutic Intervention, were undertaken in the late 1990’s; Greenhalgh, Vanhanen et al.(1998) working in Finland, Lea, Watson et al.(1998) and Watson, Deary et al.(1999) researching in the United Kingdom and Yam and Rossiter (2000) in Hong Kong.

All four research papers offer overviews of the literature on caring citing well established names such as (Kyle 1995, Morse et al. 1990, Swanson-Kauffman 1988, Valentine 1991, von Essen and Sjoden 1991, Watson and Lea 1997, Greenhalgh et al. 1998, Lea et al. 1998, Watson et al. 1999) to name but a few.



Three of the research papers, (Greenhalgh et al. 1998, Lea et al. 1998, Watson et al. 1999) take a quantitative approach to the research, whilst Yam and Rossiter (2000) follow a qualitative route. All three quantitative studies aim to investigate and describe the underlying structure of caring in nursing through exploring nursing practice.

Greenhalgh, Vanhanen et al.(1998) use the CARE-Q inventory (50 questions) in a free choice format, with participants required to use Likert scale choices to indicate agreement or disagreement with the statements.

Lea, Watson et al.(1998) and Watson, Deary et al.(1999) use a Caring Dimensions Inventory (CDI) previously designed by Watson and Lea (1997). The CDI contains 25 core questions each specifying a nursing action which participants rated as caring nursing practice using a 5 point Likert scale.

Sample groups for all the studies were similar, with nurses working in general and psychiatric areas participating, although Watson, Deary et al.'s (1999) study specifically used student nurses as a sample.

The data collected in these research studies was then analysed using appropriated statistical methods; chi-squared testing (Greenhalgh et al. 1998) and exploratory factors analysis (Lea et al. 1998, Watson et al. 1999)

Overall, the results of these three quantitative studies were remarkably similar. One argues that this, in terms of the latter two authors, should not be a surprise as these authors are working with the same tool and are part of the same research team.

Greenhalgh, Vanhanen et al.(1998) identifies 6 sub-scales of caring behaviours: monitors/follows through, explains/facilitates, comforts, trusting relationships, accessibility and anticipates. Whilst Lea, Watson et al.(1998) and Watson, Deary et

al.(1999) confirm 4 dimensions of caring as identified by nurses – these are psychosocial aspects, technical/professional aspects, giving of self and inappropriate interaction.

One suggests the first two subscales of monitors, and explains; equate to professional/technical aspects in the CDI, with comforts and anticipates equating to psychosocial aspects, and trusting relationships and accessibility matching giving of self.

Yam and Rossiter (2000) using a qualitative approach with semi-structured interviews also aimed to identify registered nurses perceptions of caring behaviours. Analysis was by content analysis using coding and categorisation to find patterns. The findings identified three categories of caring behaviours – trying one's best to meet client's needs, demonstrating effective communication and interpersonal skills, and thirdly providing a supportive environment. In discussion, Yam and Rossiter (2000) note that in meeting the needs of clients, nurses focused mainly on the physical and interventional aspects of care rather than emotional and social needs. One proposes this category equates to the technical/professional aspects defined by Lea, Watson et al.(1998) and Watson, Deary et al.(1999)

Yam and Rossiter's (2000) second category is described as valuing interpersonal skills and demonstrating the affective self; thus one suggests this matches the category identified by Greenhalgh, Vanhanen et al.(1998) as 'comforts and trusting relationships', and that categorised by Lea, Watson et al.(1998) and Watson, Deary et al.(1999) as 'giving of self'.

The third category reported by Yam and Rossiter (2000) related entirely to the environment of caring rather than caring behaviours in relation to patients, and thus does not match any of the quantitative results.

However, given the congruence of results from these four research studies in terms of technical/professional aspects of caring behaviours, psychosocial aspects, and giving of self, one proposes that Morse, Solberg et al's (1990) category of therapeutic intervention has some credence; although more research into the nature of the intervention and its effects on patient outcomes is required.

The final category from Morse, Solberg et al (1990) that has been researched is that of Interpersonal Interactions. However, only one research article from the early 1990's has been identified that specifically focuses on this aspect, that of Clarke and Wheeler (1992). One suggests this may reflect the paucity of detail in Morse, Solberg et al's (1990) article for this particular category, and they draw no conclusions about the nature of this category other than to state that the interaction within the nurse-patient relationship is the essence of caring.

Clarke and Wheeler (1992) undertake a qualitative, phenomenological study of 6 nurses in the UK, to explore the meaning of caring. The data collected, using semi-structured interviews, was then analysed using Colaizzi's seven stage reductive processes. The results allowed identification of four categories, each containing several theme clusters. The categories identified were: being supportive, communicating, pressures and caring abilities.

Clarke and Wheeler (1992) clarify that being supportive closely aligned to giving of self through developing friendships and trust with patients. Communication was demonstrated by listening, talking and being approachable; with touching and hugging patients added when nurses felt it was appropriate. The nurses identified caring as

‘responding to a continuous process of need, with the ability to care related to personal supportive networks and their own coping strategies’ (p1287).

The pressures category, Clarke and Wheeler (1992) identified as work orientated and personal, which nurses’ acknowledged reflected their ability to care and the quality of the care given. The most common pressure was lack of time that prevented the development of interpersonal relationships.

Finally, caring ability was seen as reflected in personal receipt of care, instruction and professional knowledge that resulted in nurses building personal confidence.

Clarke and Wheeler (1992) conclude that the caring experience is more to do with being concerned with what the nurse is and interpersonal aspects of care, rather than the tasks the nurse performs.

One suggests that although the academic treatises and research papers do not categorically define the concept of caring in nursing, they do add some aspects to the discussion that require further investigation. In particular, the nurse-patient relationship recurs as a theme throughout the reviewed literature and it will be returned to later in the literature review.

### **The challenge to the profession**

These repeated attempts to address the issue of caring in nursing were challenged in 2000 by John Paley. Paley has an MA in philosophy, works as a senior lecturer in a Department of Nursing in higher education but is not a nurse. One could suggest that this gives him an advantage when addressing the issue of caring as he will be less

hindered by the effects of the socialisation of nursing and personal nursing experiences and thus Paley could be considered as more objective. However, it also raises the issue that Paley might have a lack of understanding of the culture of nursing which could affect his interpretation of the situation of caring in nursing, although as he is working in a nursing department there probably has been some socialisation into the nursing culture and he may have loyalties to nursing colleagues. One proposes that this latter case is the more likely as Paley extensively criticises concepts within nursing (Paley 1997, Paley 1998, Paley 2000, Paley 2000a, Paley 2002, Paley 2002a, Paley 2004b, Paley 2002b) and mainly uses esoteric philosophical argument that is of little use to practitioners working in the wards.

Paley (2001) aims to offer a diagnosis of why nursing is no closer to clarifying the concept of caring than it was 20 years ago. In setting the scene Paley (2001) acknowledges authors such as Gadow (1980), (Gaut 1983) and Leininger (1988) as the starting point for the examination of the concept of caring and identifies Morse, Solberg et al (1990) as a seminal paper in the nursing profession's attempt to clarify the concept of caring. Nonetheless, he notes that the literature following Morse, Solberg et al (1990) returns constantly to the theme of caring as a concept remaining elusive.

Having set the scene, Paley (2001) states that his paper will give a diagnosis of why nurses have continually tried to clarify the concept of caring, a goal which Paley believes is unattainable and a result of what nursing takes to be knowledge of caring rather than the idea of caring itself.

To undertake the analysis Paley (2001) indicates he plans to concentrate on qualitative studies along with theoretical and discursive pieces of literature. There is no reason

given for this choice and one wonders whether these particular studies are selected due to a bias on Paley's (2001) part towards quantitative methods of research as one notes many of his publications are criticisms of qualitative methodologies (Paley 1998, Paley 2000c, Paley 2001a, Paley 2005, Paley 2005a). As an afterthought Paley (2001) then indicates that his ideas apply equally to quantitative studies and thus he will comment on these as well later.

Using the body of literature explored previously in this literature review Paley (2001) develops an argument of five presuppositions regarding knowledge of caring. Paley (2001) thus suggests the literature on caring is in essence literature on caring based on a secondary source, that of the nurse; providing the example of Greenhalgh, Vanhanen et al.(1998) along with several other authors (Forrest 1989, Clarke and Wheeler 1992, Nelms 1996, Beeby 2000, King and Turner 2000) as examples that support his proposal that nurses' knowledge of caring is almost exclusively knowledge of what is said about caring.

Paley (2001) reiterates his argument that knowledge of caring is an aggregate of 'things said' which consists of endless series of associations grouped into attributes based on resemblances. He suggests 'associations' are thought of as a description of the 'phenomenon' of caring, whilst 'attributes' are a theoretical account of the phenomenon. Because of this, Paley (2001) states that description is indefinitely elastic, and theoretical accounts can be multiplied due to the adoption of different combinations of attributes. Thus, according to Paley (2001) the 'caring' literature has, so far, covered a very small proportion of the available research combinations. He suggests that because

of this there is always another batch of ‘things said’ to be added to the expanding universe on caring.

Paley’s (2001) main point here is that knowledge works through aggregation, and therefore, each successive set of research results is quite likely to replicate earlier work to a considerable degree. Although Paley (2001) does concede that it may also identify new ‘things said’ however, he tempers this by adding (*apparently*) which one suggests shows he is sceptical of this idea.

Paley (2001), at this juncture, adds that the relatively small number of studies that focus on patients’ perceptions have the same feature. One wonders why Paley (2001) waited until this point to acknowledge the patient research, particularly as he concludes that patients represent another permutation in the research space of ‘caring’, and so all his previous comments apply equally to the patient research.

Undertaking a similar analysis process, Paley (2001) then indicates that it is easy to show that quantitative knowledge of caring is still knowledge of ‘things said’ and incorporates the same knowledge presuppositions about caring as the qualitative and theoretical approaches. One does have to question, then, why Paley (2001) felt the need to undertake a separate section on the quantitative approach, and one wonders is this perhaps due to a personal bias on Paley’s part, or did a reviewer of the article indicate this was a lack in the submitted work that Paley (2001) has redressed by his sentence in the introduction to the presuppositions where he indicates he will also address the quantitative studies later, and has then inserted this section.

Paley (2001) surmises that the distinctive feature of quantitative studies in caring is the way they use factor/component analysis to devise their ‘theme clusters’. Paley (2001)

indicates that although this process is obviously different from ‘resemblances’ detected by qualitative analysis the procedures are intended to achieve the same clustering of associated items into attributes.

In a concluding paragraph to this section on quantitative studies Paley (2001) summarises his theme of all caring research drawing on ‘things said’ by nurses, but indicates the difference with the quantitative studies is the use of larger and more differentiated sample groups. Paley (2001) argues that the quantitative researchers’ analysis fulfils the same purpose as the qualitative research and that knowledge of caring is still knowledge through aggregation. This being the case, Paley (2001) concludes, as in qualitative research, there is no limit or end point to the accretion of knowledge.

This conclusion being the case, one is hard pushed to understand why Paley (2001) felt the need to deal with quantitative studies as a separate group from the rest, as his argument remains the same for all research approaches.

The crux of Paley’s (2001) diagnosis is that as nursing knows ‘caring’ only as a procession from one association to another, with no final end point being reached, it remains an elusive and complex concept. Paley (2001) suggests this has nothing to do with caring directly, but has to do with how knowledge of caring is understood. This, Paley (2001) indicates, is the endlessness consequence of this approach to studying caring in nursing.

Following this, Paley (2001) then explores the aspect of uselessness, which he argues is a crucial feature of lists of attributes. Paley (2001) states that there is no possibility that knowledge of this kind can be challenged or contested. Associations, Paley (2001) suggests, do not produce accounts that can be discriminated from each other because the



knowledge gained is an accumulation of 'things said' rather than alternative ways of seeing reality. Therefore, Paley (2001) concludes, the knowledge is useless; it cannot be tested nor even applied.

Paley's (2001) contribution to the literature does assist in clarifying the debate around the concept of caring in nursing. His challenge to the profession establishes that there are five ways of conceptualising caring in nursing. These are; by description, 'things said', caring associations, caring attributes and aggregation of caring knowledge. This in itself, regardless of Paley's criticism, assists in developing a framework that could support the analysis of the data collected through the research.

#### **Further explorations of caring.**

Although Paley (2001) challenged the profession of nursing to abandon the search to define the concept of caring, his argument appears to have been disregarded. Several authors have continued the process of attempting to define the concept of caring in nursing (Sumner 2001, Tarlier 2004, White 2002, Kapborg and Bertero 2003, Skott and Eriksonn 2005, Wilkin and Slevin 2004). No mention is made by these authors of Paley's challenge, nor do they justify why, in the face of it, they have continued to search for a definition.

These authors (Skott and Eriksonn 2005, Sumner 2001, Tarlier 2004, White 2002, Wilkin and Slevin 2004, Kapborg and Bertero 2003) along with Paley (2002b), take several different approaches to the continuing drive to define the concept of caring. Four articles explore the moral and ethical dimensions of caring (Skott and Eriksonn 2005, Sumner 2001, Tarlier 2004, White 2002).

Sumner (2001) takes the stance that caring in nursing is rooted in the nurse-patient relationship, fitting with Morse, Solberg et al (1990) category of interpersonal interaction. To justify the work Sumner (2001) indicated that although many authors, including Griffin(1983), Watson (1985), Roach (1987), Swanson-Kauffman (1988), Leininger(1988b), and Morse, Solberg et al (1990) have described caring in nursing, it still remains a nebulous concept.

To offer a different perspective Sumner (2001) uses Habermas's Theory of Moral Consciousness and Communication to allow synthesis of the complex components of caring in nursing.

Sumner (2001) identifies the main aspects of Habermas's framework as being the three normative claims to validity: the claim to truth – is the factual world of the individual, the claim to truthfulness – the intra-subjective world of the individual including values, beliefs and emotional responses, and the claim to right – relational interaction between participants or between participant and inter-subjective world.

These normative claims are applied by Sumner (2001) to the nurse-patient relationship identifying that all discourse is limited to a specific situation with relevant content which requires a shared understanding, with the success of the discourse depending on the level of maturity the participation occurs at.

Sumner (2001) argues that depending on the level of maturity, the discourse ranges from use of strategic actions which is coercive, to the use of communicative action which is co-operative. One notes particularly this notion of level of moral development of the patient and nurse affecting maturity. Unquestioning acceptance of rules and norms is the pre-conventional level of maturity, and is an egocentric, subjective experience. The

conventional level of moral development is concrete, with recognition of some reciprocity and recognition of others, with non-questioning acceptance of duty, obligation and norms. Finally, the post-conventional level of moral development is demonstrated by mutuality, with norms questioned and justified. One suggests this issue of moral development may affect the patient's experiences of care and therefore may be important in the proposed research, in terms of both the patient and the nurse.

Sumner (2001) proposes that the interaction lies in the normative claim to right, where there is a mutual acceptance of the values and norms embedded in the action, with an accepted goal identified. Again, one suggests that the issue of mutual acceptance may be crucial in the proposed research in explaining the patient's experience of care.

Concluding that caring in nursing through the nurse-patient relationship is a moral ideal of egalitarianism through negotiated agreement of a course of action Sumner (2001) suggests Habermas's theory provides a useful frame in describing caring in nursing. One would suggest that through this argument Sumner's (2001) work aligns well with Morse, Solberg et al's (1990) category of caring as a Moral Imperative.

A similar base of moral imperative is used by White (2002) in discussing caring in nursing within the framework of nursing as a vocation. White (2002) draws on philosophical and ethical bases from Blum (1993) to argue that vocational action is motivated by caring, which includes nurses having a certain disposition, care abilities, knowledge and skills to fulfil the role. White (2002) concludes that 'the notion of vocation is crucial to nursing if nursing wants to continue to accord primacy to caring, or at least take seriously the notion of caring about a patient' (p288).

The notion of a particular disposition for nursing could inform the patient's experiences of care in this thesis.

Situating the concept of caring in nursing within a bureaucratic healthcare system, Stickley and Freshwater (2002) explore the concept of caring in relation to the nurse-patient relationship. Focussing on the issue of love within the therapeutic relationship Stickley and Freshwater (2002) link the notion of love to caring, using Roach (1987) and Watson (1998) as justification for the use of love and arguing that the caring or therapeutic relationship is essential to the healing process of the patient, and in order to facilitate a caring relationship, the nurse must be able to love.

However, Stickley and Freshwater (2002) suggest that the current technological and bureaucratic healthcare systems erode the ability of the nurse to develop caring relationships due to lack of time, resources and cost constraints.

The final author to address caring as a moral imperative is Tarlier (2004); who is the first author to acknowledge Paley's (2001) criticism of the claim of caring central to nursing, suggesting that caring has become a point of controversy among nurse theorists. Using several papers (Benner and Wrubel 1989, Leininger 1985, Paley 2002b, Watson 1985) Tarlier (2004) argues that the focus on caring has been at the expense of understanding the relationship between caring and the broader ethical knowledge of nursing. Caring, Tarlier (2004) suggests, is a means of describing the complex aspects that are the bases of the nurse-patient relationship, making visible ethical knowledge that occurs incidentally as nurse's use an underlying broader philosophy in their daily nursing practice.

Tarlier (2004) argues that nurse-patient relationships are responsive, if they are based on three essential elements – trust, respect and mutuality. This responsive relationship, encompasses and provides a framework for caring behaviours and actions, and implies collaboration, negotiation and sharing of knowledge and power. Concluding that by articulating the moral and ethical basis of nursing Tarlier (2004) argues she has shown that responsive nurse-patient relationships reflect more than just caring. As Paley (2001) before her, Tarlier (2004) suggests it is time for nursing to get beyond the ideological debate around caring and focus on the issues of a responsive nurse-patient relationship. The issues raised in these articles relating to the nurse-patient relationship will be explored as part of the proposed research.

Three further researchers undertake to continue the exploration of the concept of caring through research rather than academic treatise (Kapborg and Bertero, 2003, Skott and Eriksonn, 2005, Wilkin and Slevin, 2004). All these researchers identified the aim of their research to be the exploration of the meaning of caring using qualitative methods. Kapborg and Bertero (2003) identify the concept of caring from the perspective of student nurses in Sweden. Similarly, Wilkin and Slevin (2004) explored intensive care nurses in the UK's views of caring and Skott and Eriksonn (2005) working in Sweden, used a case study approach to discover the content of individual acts of caring.

All researchers include an introduction to the concept of caring which revisit previously identified authors. One suggests this is not unexpected given the amount of literature surrounding the concept of caring in nursing. Interestingly, Wilkin and Slevin (2004)

justify their study by citing Paley's (2001) criticism of the exploration of caring, and argue that their study illustrates what nurses see themselves as.

Methodological approaches differed with Kapborg and Bertero (2003) using essay analysis, Wilkin and Slevin (2004) semi-structured interviews and Skott and Eriksonn (2005) hermeneutic interpretation of one nurse's clinical diary. Sample selection was through purposive sampling, with Kapborg and Bertero's (2003) sample containing 132 student nurses, and Wilkin and Slevin (2004) selecting their sample from 46 intensive care nurses. Wilkin and Slevin (2004) do not indicate a final sample size but indicate saturation of data was achieved after 12 interviews. Skott and Eriksonn (2005) did not use a sampling approach rather their data resulted from a conversation between the authors which culminated in Eriksonn, a nurse in an oncology ward, keeping a clinical diary for six months.

Content analysis of data is used by Kapborg and Bertero (2003) and Wilkin and Slevin (2004) with the latter detailing the use of Coliazzi's seven stage process of analysis, to develop themes and categories.

In interpreting the diary Skott and Eriksonn (2005) use a three step process, firstly the diary was read as a whole and discussed, with identification of episodes of care occurring. Next each activity was de-contextualised; to assist in grasping the meaning of the text, Skott and Eriksonn (2005) use a combination of quantitative and qualitative content analysis. Finally the findings were re-contextualised, although one is not informed of how this was done. One suggests that as the diary had been kept by one of the researchers, the inclusion of this person in the data analysis may have affected the

results, as potential exists for the interpretation of the episode of care to be reconstructed by the researcher in a manner that might bias or alter the true results.

All three pieces of research identified three categories or themes from the data but used different terminologies to identify their themes, however, their explanations of these themes allows one to identify that the findings are similar in content.

The first theme, identified by Kapborg and Bertero (2003), was 'doing' which indicated physical presence with patients and undertaking actions and treatments. One suggests this theme is synonymous with Wilkin and Slevin (2004) theme of nurses' skills, which includes physical care, practical and emotional support and barriers to care; finally, Skott and Eriksonn (2005) categorise 'physical care' as a theme. Therefore one proposes that nurses see physical care as a main area of their role.

'Being' is the second theme from Kapborg and Bertero (2003), and was seen as connecting with the patients through listening, being concerned for comfort, showing empathy and offering emotional and psychological care. Similarly, Wilkin and Slevin's (2004) category of nurse's feelings correlates with this as it involves comfort, empathy, touch, presence and holistic care and Skott and Eriksonn (2005) have a category of 'reflection' that involved issues of feeling, and in particular emotion, although in their category the emphasis is on the nurse's internal feelings toward self rather than towards the patient.

The third theme identified by Kapborg and Bertero's (2003) work is 'professionalism'. This theme is explained as competence through having knowledge of theory and practice, understanding of rules and regulations, an ability to deal with ethical and moral issues and finally prevention through use of clinical care and health promotion. The

related theme in Wilkin and Slevin (2004) is that of 'nurse's knowledge' which includes knowledge of technology, knowing the patient, prioritising care and critical situations. No similarity was found between these two themes and Skott and Eriksonn's (2005) final theme of communication. One suggests that Skott and Eriksonn's (2005) themes might change if a greater number of diaries were kept and reviewed rather than relying on one example.

One proposes that the findings from these researchers further confirm that, regardless of a lack of definition of caring in nursing, nurses themselves have a clear idea of the integrated nature of care, and can clearly define what caring means to them regardless of the stage of their career. This, one suggests, can be further explored in this research to establish whether nurses have a shared conceptualisation of care or many individual philosophies of care.

### **An evolutionary concept analysis of caring.**

The process of seeking a definition of caring in nursing culminates in another major attempt to identify the core enduring attributes of nursing care. Brilowski and Wendler (2005) use an evolutionary concept analysis to, they state, clarify the concept of caring.

Commencing their analysis Brilowski and Wendler (2005) acknowledge the role played by Leininger and Watson in the early 1980's in raising the profile and research into the concept of caring and note that the term caring only became a separate identifiable term in the Cumulative Index of Nursing and Allied Health Literature (CINAHL) in 1988. The significance of the inclusion of caring to CINAHL at this time is not explained and leaves the reader to draw their own conclusions for this inclusion as a separate item in



the database at that date. One might postulate that the body of literature on caring in nursing had, by 1988, become relatively substantial and therefore the term merited inclusion in its own right. Brilowski and Wendler (2005) conclude the introduction by identifying that the purpose of the paper is to use Rodgers's (1989, 2000a, 2000b) evolutionary concept analysis to clarify the concept of caring in nursing.

One suggests that at this point an exploration of Rodger's work will assist in clarifying the concept analysis approach used by Brilowski and Wendler (2005) as it is not well articulated in their paper.

Rodgers (1989) suggests that the popular approach in concept analysis in nursing is that outlined by Walker and Avant (1983) which offers a static view of the world, believing that concepts do not change over time and stay constant over differing contexts. This view, Rodgers (1989) notes has fallen into disrepute with the demise of positivism in nursing research, and yet at the time of her writing this form of concept analysis was still favoured in nursing.

A dispositional view, Rodgers (1989) proposes, would get round some of the difficulties presented by the entity approach by overcoming the distinction between public and private ways of thinking, focussing on the use of the concept rather than its essence. Rodgers (1989) notes that an approach to concept analysis that values dynamism and interrelationships within reality, has yet to be available to nursing. She suggests that the evolutionary view, as detailed in her doctorate, offers such an approach with the notion of development and refinement of a changing concept showing the emphasis of evolution within the evolutionary analysis approach. Rodgers (1989) indicates three distinct influences are seen to affect concept development, firstly that of significance. A

concept that is considered significant, Rodgers (1989) suggests, will be used often and widely and this influences development of variations and innovations in the concept.

The second influence, use, is the commonly accepted way the concept is employed, its application in appropriate situations and the form of its use, whether that is through language or behaviour.

Rodgers's (1989) third influence, application, is treated differently in the text, being given a whole section in the article. One would suggest this is due to the importance Rodgers ascribes to it. In terms of the influence of application, Rodgers (1989) suggests that as a concept becomes linked with a particular use this understanding is passed on through education and social interaction, and effort is made to apply the concept to new situations resulting in establishing the scope of the concept. Through application concepts can be refined and variations introduced that enhance the concept's explanatory powers. Consequently, the application assists in revealing the strengths and limitations of the concept.

However, Rodgers (1989) suggests that over time a concept can become ambiguous as individuals are unable to articulate the concept's attributes and situations that are appropriate for its use. One postulates that this is the situation that caring has arrived at in nursing given Paley's (2000) criticisms, and the continuing inability of nursing to define its relationship to caring.

Rodgers (1989) explains the method of evolutionary concept analysis as primarily a means of identification of what is common in the existing uses of the concept. The method involves a number of phases that do not occur in a linear fashion, and many of

these activities occur simultaneously throughout the investigation representing tasks to be undertaken rather specific steps in the process.

Table 2.1 The method of analysis (from Rodgers (2000a) (page 85))

1.	Identify the concept of interest and associated expressions (including surrogate terms)
2.	Identify and select an appropriate realm(setting and sample) for data collection
3.	Collect data relevant to identify: a. the attributes of the concept b. the contextual basis of the concept, including interdisciplinary, socio--cultural and temporal (antecedent and consequential occurrences) variations.
4.	Analyse data regarding the above characteristics of the concept
5.	Identify an exemplar of the concept, if appropriate.
6.	Identify implications, hypotheses and implications for further development of the concept.

In conclusion, Rodgers (2000a) comments that evolutionary concept analysis offers an approach that circumvents the difficulties concerning the separation of mental and physical domains of reality, and takes account of the dynamic and inter-related nature of the world. Thus it presents a contemporary challenge to nursing regarding the foundation and practical implications of existing concept analysis methods. Through the evolutionary approach, Rodgers (2000a) maintains that nursing may be able to enhance the continuing development of knowledge.

One suggests, however, that the discipline of nursing is still struggling to shed the legacy of the logical positivist approach. A CINAHL search for literature using the term 'evolutionary concept analysis' and restricted to English, resulted in 689 results. Of these 10% were using the evolutionary approach and the rest were based on Walker and Avant's (1983) concept analysis, which is rooted in the positivist tradition. Thus it seems nursing is more comfortable with this approach, rather than the more dispositional

method, which may reflect the continuing allegiance of nursing to the medical traditions of scientific enquiry as a means of supporting the argument that nursing is a profession.

To justify their choice of Rodgers's evolutionary approach, as opposed to Walker and Avant's (1999) traditional concept analysis, Brilowski and Wendler (2005) argue that by using Rodgers's (1989, 2000a, 2000b) evolutionary concept analysis the evolution of a concept, through a series of related changes in a certain direction, can be identified, put together and analysed to allow the concept to be explored for its significance and application over time. This allows tentative knowledge and understanding of the concept to be gained through scholarly activity.

One has concerns over the use, by Brilowski and Wendler (2005), of the term tentative, as the issue stated is to identify the core concepts of caring in nursing. Therefore, one would suggest, a greater indication of confidence in the results of the concept analysis would be essential.

The aim of Brilowski and Wendler's (2005) study was stated as an examination of the evolution of the concept of caring within the nursing discipline. Brilowski and Wendler (2005) detail their sampling method to illustrate their adherence to Rodgers's (1989, 2000a, 2000b) requirement of a rigorous and scholarly method of sample selection. Using CINAHL, which Brilowski and Wendler (2005) indicate is the most comprehensive electronic database for nursing, and the keyword 'caring' they gained over 6000 articles. This search was then restricted to articles in English; one presumes this was to facilitate reading and comprehension of the articles, although this is not stated. A further restriction of the search was to articles published in core journals, as

identified by CINAHL. The definition of how a core journal is defined by CINAHL is not indicated by Brilowski and Wendler (2005) and this could mean that crucial articles were missed in the selection process. Finally, the search was limited to post 1988 publication, with the rationale that this was the benchmark date for emergence of the concept, as it first appeared as a separate keyword in CINAHL in that year.

Following this process of selection, Brilowski and Wendler (2005) were left with 670 articles, all of which were read; one assumes they are read by the two authors but this is not indicated. Brilowski and Wendler (2005) then excluded those that contained what they define as procedural categories, such as nursing care, care givers, and patient-centred care, without indicating why these procedural categories require elimination from the sample, nor how this fits with the study's aim.

Similarly, articles that related to administrative aspects of caring such as organisational culture and management theory were also excluded as Brilowski and Wendler (2005) state they want to focus on the nursing experience of caring. This being the case, one is still left wondering about this exclusion and the initial exclusion of procedural categories because presumably these aspects are crucial elements to the nursing experience of caring. By excluding this section of the literature one suggests Brilowski and Wendler (2005) do not rigorously follow Rodgers's (2000a) method of analysis and may miss essential attributes of caring that would assist in defining caring. Finally, Brilowski and Wendler (2005) exclude all articles that involve survey research; on the grounds the articles did not offer theoretical data of use to the aim of the study. Again one has difficulty in understanding this exclusion as the aim of the study is to examine the

evolution of the concept of caring in nursing and some of that understanding must arise from the results of survey research such as that undertaken by Lea et al.(1998).

One begins to question whether Brilowski and Wendler (2005) have an un-stated underlying perspective of the concept that they are biased towards, and that this is dictating their sampling of the literature.

Finally Brilowski and Wendler (2005) then deliberately include anecdotal and individual case descriptions as they argue that these give important contextual information, but without expanding on what that contextual information is. A final total of 283 articles were selected by Brilowski and Wendler (2005) to meet the inclusion criteria. As inclusion criteria have not been addressed specifically by Brilowski and Wendler (2005) one cannot judge whether those criteria are appropriate for the aim or not.

Following Rodgers's evolutionary approach, Brilowski and Wendler (2005) then apply a random selection process to the 283 articles aiming for a 25% target sample, in order to achieve a 20% minimum of articles that meet the inclusion criteria. Random selection was achieved by selecting a piece of paper containing a number from 1 – 4, from a container (in effect number 4). The final sample selection then commenced from article number 4 in their list, and thereafter every fourth article was selected, which resulted in a total sample, according to Brilowski and Wendler (2005) of 68 articles. One is not informed of how the articles were listed, whether alphabetically by author, title or by journal, so it is difficult to assess the objectivity of this process. Similarly selecting every fourth article should have resulted in 70 articles not 68 but this discrepancy is neither noted nor explained in the text.

Brilowski and Wendler (2005) explain that following reading of the articles, notes were written but data analysis did not commence, in order that premature conclusions were not drawn, stating Rodgers (2000a) identifies this as a major limitation of evolutionary concept analysis. However, according to Brilowski and Wendler (2005), the reading identified 7 articles that did not yield data relevant to the concept and these articles were therefore excluded. One has to suggest that if this was the case some data analysis must have been occurring to enable this decision to be made, and thus conclusions had been drawn.

Again one does not know what Brilowski and Wendler's (2005) criteria for inclusion were, nor what the 7 articles were, so the veracity of the reading process cannot be established. Finally, 61 articles, which equates to 21.6% inclusion rate from the total literature search were formally reviewed. Brilowski and Wendler (2005) do not specifically comment that this meets Rodgers (1989) requirement for over 20% inclusion of a random selection of articles from the total literature identified, and one feels this omission reduces the credibility of their work.

Brilowski and Wendler (2005) commence data analysis by creating a coding system, where the data regarding attributes of the concept, context factors and related or surrogate concepts are identified and recorded on individual coding sheets. One has to assume that each article has its own coding sheet as this is not made explicit in the text. No indication is given of the nature of the coding system, so again one cannot establish the appropriateness for this study. The coding sheets were reviewed for recurrent themes, which Brilowski and Wendler (2005) identified as categories. These are

highlighted by use of italics in the text and consist of: significance, use and application with caring as the focus of the review. One notes these categories were identified by Rodgers (1989) as the three distinct important influences on concept development using an evolutionary approach. Therefore, Brilowski and Wendler (2005) may have highlighted them as a means of indicating their important for concept analysis.

Continuing their description of the analysis, Brilowski and Wendler (2005) state that word labels were selected that best illuminated the nature of the data and indicate a nursing scholar with experience of the evolutionary concept analysis approach reviewed the raw data and then agreed the word labels. One has, again, to assume that this is an attempt by Brilowski and Wendler (2005) to increase the veracity of their data and analysis but this is not stated. Finally Brilowski and Wendler (2005) group the articles by emerging theme and then collapse them into a synopsis which is developed as findings. Brilowski and Wendler (2005) again do not explain how they collapsed the data to get their findings and so one cannot make any judgement regarding the process or the reliability of the findings.

Discussing the findings, Brilowski and Wendler (2005) suggest their concept analysis identifies five attributes of caring within nursing: relationship, action, attitude, acceptance and variability. Brilowski and Wendler (2005) define these attributes using the unabridged Webster 3<sup>rd</sup> edition New International Dictionary, and present the definitions of the attributes in a table in the order that they appear in the analysis and include page numbers against the definitions which allows one to verify the accuracy of the definitions.



Brilowski and Wendler (2005) report the findings in the order that they appear in the analysis, and it is at this point in the article that one can start to identify the 61 articles used as their sample.

The first attribute identified from the data was that of relationship. As Brilowski and Wendler (2005) do not explicate their coding system nor their themes it is difficult to establish the appropriateness of the allocation of authors to this attribute. From personal review of the primary sources, it would seem that this attribute is identified from work that explores the nature of caring as containing a connectedness/professional friendship between the carer and recipient of care. Two authors in this attribute, Fealy (1995) and Boykin et al.(1994), establish that the relationship develops by a nurse identifying, from their knowledge, a need for assistance in another explicitly due to illness, crisis or inability to self-care, and then being motivated to act; reflecting Morse et al's (1990) category of therapeutic relationship. Brilowski and Wendler (2005) do not undertake any analysis of their selected articles, only describing the notion of relationship and its importance by using references to the literature. They suggest that the responsibility for development of the relationship is on the person providing the care, and argue that all care actions by the professional carer must be based on current knowledge. Brilowski and Wendler (2005) propose that professional ethical codes provide nurses with a structure within which to make decisions and have high standards of behaviour.

What Brilowski and Wendler (2005) do not do, is draw any conclusions in relation to the theme of relationship and the lack of any analysis or cohesive discussion leaves one wondering about this attribute and its relationship to nursing, as the notion of the caring

encounter is not exclusive to nursing professionals but to any other health professionals- an issue clearly identified by Halldorsdottir and Hamrin (1997), one of the articles in Brilowski and Wendler's (2005) sample.

The second attribute identified by Brilowski and Wendler (2005) was that of action; noted as the dominant theme in the concept analysis. One suggests that this, in itself, is an interesting feature, as Brilowski and Wendler (2005) had specifically excluded from their literature, articles that were identified as having procedural categories such as nursing care and technical skills and now these types of action are found as dominant in the concept analysis.

Brilowski and Wendler's (2005) sample articles indicate action in the form of doing for the patient, or being with the patient, as being dominant in the caring process. In reviewing two of the cited primary sources for this attribute; those of Fealy (1995) and Halldorsdottir and Hamrin (1997), it becomes clear that the notions of competence in technical/rational skills, communication, decision-making and relating to patients are the crucial components of professional caring as defined by the recipients of care, and professional caring includes some unidirectional action on the part of the carer. Thus, Brilowski and Wendler's (2005) initial exclusion of procedural categories may have skewed the nature of the results of their analysis. On the other hand, one could argue that, by excluding procedural categories, only to have action become a dominant theme in the concept analysis could allow them to argue that 'action' is the mainstay of caring in nursing. However, Brilowski and Wendler (2005) do not address this point at all in

their article and thus miss an opportunity to finally offer a definition of a caring in nursing.

Continuing to discuss the attribute of action, Brilowski and Wendler (2005) identify four important actions; nursing care, touch, presence and competence, based on a single article by From (1995).

Reading this primary source, one finds that this is an anecdotal article by an American nurse lecturer (From (1995)), who asked 6 students what caring meant to them, reproducing their responses verbatim. From these Brilowski and Wendler (2005) identify their four actions. One finds it difficult to clearly identify any of these actions specifically in the original article and could suggest that Brilowski and Wendler (2005) have imposed their own interpretations on the students' responses to allow them to suggest these four actions because the actions fit with the focus of the sample articles in this attribute.

Brilowski and Wendler (2005) continue by describing and justifying their choice of actions using reference to a number of articles in their literature sample (Gullo 1998, Clapham 1992, Danielson 1996, Ebersole 1996, Fredriksson 1999, Hallock 1994, Mallory 1988, Pryds-Jensen et al. 1993, Sanford 2000, Smith 1991, Ufema 1994, Welch 1999).

In exploring Brilowski and Wendler's (2005) justification of nursing care and touch, one finds it relies on verbatim quotes from several anecdotal sources (Danielson 1996, Hallock 1994, Mallory 1988, Ufema 1994). Other substantive research papers (Clapham 1992, Ebersole 1996, Fredriksson 1999, Pryds-Jensen et al. 1993, Smith 1991) are also used to illustrate Brilowski and Wendler's (2005) argument. However on review of these

it is apparent the Brilowski and Wendler (2005) are selective in their interpretation of the results, ignoring aspects of the research that are less beneficial to their argument. In particular, Fredriksson's (1999) work is used to support the action of presence. However, Fredriksson (1999) focuses on modes of relating in caring conversations rather than being an attempt to analyse caring. It is used by Brilowski and Wendler (2005) to support their discussion, however, one suggests that Brilowski and Wendler (2005) have extracted and slanted elements of the work to fit their purpose rather than developing their discussion from the research results.

Similarly in their exposition on competence Brilowski and Wendler (2005) use two primary sources (Sanford 2000, Welch 1999) which relate to the effect of educational processes to support their notion that understanding of human and physical science and its interaction with the humanity of patients and family is crucial to good care. One assumes Brilowski and Wendler (2005) interpret the curriculum as reflecting the human and physical sciences to allow them to use these articles. However, this notion of the effect of educational processes on nurses' caring behaviours may be significant for this thesis.

Brilowski and Wendler (2005) follow with a statement from page 123 of Halldorsdottir and Hamrin (1997) that states "caring without competence is meaningless". The indication of the page number allows one to confirm the veracity of this statement and on review of the original article one discovers that Brilowski and Wendler (2005) have again been selective in their use of the evidence. The actual sentence in Halldorsdottir and Hamrin (1997) is 'Caring without competence was in most cases meaningless for them as patients' (p123). One can see that this then changes the focus of the statement as

it is the patient's view that is being propounded, rather than Halldorsdottir and Hamrin's (1997) view. However, Brilowski and Wendler (2005) imply in their text that it is Halldorsdottir and Hamrin's (1997) view that they are using to justify the importance of clinical competence in caring. Using evidence from Locsin (1995), Happ (1996) and Thompson (1996); whose articles focus on technology as one aspect of caring ,

Brilowski and Wendler (2005) finish by stating that competency alone is not considered to be caring.

As previously, Brilowski and Wendler (2005) do not attempt any analysis or discussion of the action of competence nor do they draw a conclusion for the attribute of action and therefore, one is left draw one's own conclusions from this section.

The third attribute of caring identified by Brilowski and Wendler (2005) is that of attitude. They suggest that analysis of the literature sample revealed that a particular positive attitude presented by the nurse, that of 'caring about' allows the nurse to be considered as caring. As with previously, on review of the original articles one again finds that Brilowski and Wendler (2005) are being selective in their interpretation. Using several authors work (Fealy 1995, Halldorsdottir and Hamrin 1997, Pryds-Jensen et al. 1993, Watson 1990) to support their arguments Brilowski and Wendler (2005) conclude that attitude is an important attribute for a caring nurse. What they do not do is identify that their conclusions are based on small phenomenological studies of patients' and nurses views of caring, nor do they draw any comparison between the patients' views and those of the nurses to show if there is any congruence in the findings. This

would have allowed Brilowski and Wendler (2005) to strengthen their conclusions regarding attitude being important.

A fourth attribute of caring, that of acceptance is produced in Brilowski and Wendler's (2005) concept analysis results. They state that five authors in their literature sample viewed acceptance of another as a fellow human being to be critical to caring (Benner 1991, Pearson et al. 1997, Schroeder 1995, Smith 1999, Wurzbach 1990). Brilowski and Wendler (2005) also state that one person cares for another as they are fellow human beings, worthy of respect and dignity and that this is the most compelling reason to care. This assertion is justified using a number of authors work where again Brilowski and Wendler (2005) interpret the literature to suit their argument (Boykin et al. 1994, Fealy 1995, Gullo 1998, Halldorsdottir and Hamrin 1997, Hartrick 1997, Lindholm and Eriksson 1993, Oulton 1997, Sanford 2000).

For example, in reference to nurses being concerned with a patient's spiritual well-being as well as their physical and emotional well-being, Sanford's (2000) work is used as evidence, although on careful reading of Sanford's (2000) original article one was unable to locate any specific reference to spiritual well-being and one, therefore, assumes that Brilowski and Wendler (2005) have interpreted Sanford's (2000) notion of holistic care to include physical, emotional and spiritual well-being. Similarly, in arguing that nurses attempt to confirm a patient's dignity, and recognise that patient's are intrinsically valuable, precious human beings by acknowledging what the patient has to say as being important, and that the patient's view of the world is fundamental to nursing, Brilowski and Wendler (2005) use Lindholm and Eriksson's (1993) paper as a

major source. Lindholm and Eriksson's (1993) research paper was on understanding suffering, and on close reading of this primary source it would appear that Brilowski and Wendler's (2005) assertion that validating what a patient says as important comes their interpretation of the nurse's views on alleviating suffering in Lindholm and Eriksson's sample (11 nurses), rather than the patient sample. This inclusion of an article on suffering in a literature sample that was selected using a key word of caring in the title and/or abstract is intriguing. On closer review of the title "To understand and alleviate suffering in a caring culture" one can see how it came to be included in the initial selection. However, as the main thrust of the article is clearly about defining suffering rather than focussing on caring, one finds inclusion of this in the final sample selection group is interesting particularly as Brilowski and Wendler (2005) state they did not analyse the articles on initial read through as they did not want to pre-empt the evolutionary concept analysis.

However, one suggests that the general theme of this attribute relates clearly to Morse et al.'s (1990) category of caring as a Human Trait and so is a valid attribute.

The fifth and final attribute that Brilowski and Wendler (2005) identify through the concept analysis process is that of variability which they state appeared frequently in the sampled literature. However, they do not support this statement with reference to a large literature base, only referring to six authors (out of 68) who indicate caring is fluid and malleable and changes depending on circumstances, environment and people (Brown 1993, Cameron 1991, Fealy 1995, McCance et al. 2001, Schattsneider 1992, Warelow 1996). Brilowski and Wendler (2005) using Benner (1991) to support their argument,

suggest that variability is an aspect of care that is learned through experience, and therefore, the nature of the caring approach will change or evolve as a nurse becomes more proficient in their practice. No further discussion or analysis is offered by Brilowski and Wendler (2005) on the attribute of variability. However, this notion of variability in caring will be explored in the research.

Having established their five attributes of caring through the concept analysis Brilowski and Wendler (2005) move on to the next stage of the evolutionary concept analysis – that of examining antecedents and consequences of the concept. Using what is stated as a direct quote from Rodgers (2000b) page number 91, Brilowski and Wendler (2005) explain why exploring the contextual aspect of the concept is important. Scrutinising the primary source one established that what Brilowski and Wendler (2005) present as a direct quote is, in fact, inaccurate. On revisiting the primary source it is clear that the reference Brilowski and Wendler (2005) use should be to Rodgers (2000a) in their reference list which matches the page number for the quote, and one was able to identify the sentence on that page. Once again this lack of accuracy on the part of Brilowski and Wendler (2005) causes one to query the reliability of their work and one questions whether these inaccuracies arise from a lack of rigour in presentation of the work or a lack of real understanding of the analysis approach being used.

Brilowski and Wendler (2005) argue that the literature sample gave ample descriptions of the attributes of caring but well developed antecedents to the attributes were unavailable. They also suggest that many of the identifiable antecedents focussed on



those actions that were personified within the nurse. Using examples from Watson (1990), Hartrick (1997) and Sanford (2000) that state caring requires moral action and passion, Brilowski and Wendler (2005) propose that caring is only possible when the nurse has an understanding of self, and can appreciate humanity in others.

One notes that neither of the primary sources of Hartrick (1997) and Sanford (2000) specifically indicate Brilowski and Wendler's (2005) conclusion and one is again reliant on Brilowski and Wendler's (2005) interpretation of the ideas propounded by these articles to justify the argument.

Brilowski and Wendler (2005) also indicate that trust, support, individual and organisational commitment are all important antecedents but do not say why. Surprisingly, Brilowski and Wendler (2005) only use one article, Ebersole (1996) to support their assertions regarding trust and rapport. One is puzzled by this as many of their primary sources; for example Pryds-Jensen et al. (1993), Halldorsdottir and Hamrin (1997), Hartman (1998) and Fredriksson (1999) all refer to the issues of trust and rapport in the caring relationship and inclusion of these authors as evidence would have strengthened Brilowski and Wendler's (2005) case for including these two areas as antecedents. Similarly only one reference, Schroeder (1995), is used by Brilowski and Wendler (2005) to support the antecedents of individual and organisational commitment, when again several authors (Fealy 1995, Hartrick 1997, Owen-Mills 1995a) support the individual commitment aspect, and Tuck et al (2000) the organisational commitment.

Based on their description, Brilowski and Wendler (2005) argue that without antecedents of trust, rapport, individual and organisational commitment, factors that include reduced bedside nursing time, prolonged nursing shortages, decreased length of

stay of patients and cost containment may affect nursing care in a negative way. They do not clarify what the negative way might be and one has to assume that it is to do with reduced patient satisfaction and nurse dissatisfaction with the care that is delivered. This issue will be an important area to investigate within the research.

Brilowski and Wendler (2005) go on to conclude that time to care is a critical antecedent to nurse caring, and that time to care is assumed to be available. One is left wondering where this idea of time to care has been developed from and by whom, as no evidence is offered by Brilowski and Wendler (2005) to support the assertion, and the claim is not clearly related to their previous discussion on the antecedents of the concept of caring.

Moving on to the consequences of caring; Brilowski and Wendler (2005) state that these were clearer to identify in the literature than the antecedents, and the majority of the consequences were positive for the nurse, patient/family or both. Brilowski and Wendler (2005) refer to only two articles as evidence for this; an anecdotal reflective piece by Hilt (1993) and Fealy's (1995) article on professional caring – the moral dimension. One can clearly see, through the three anecdotes of care situations illustrated in Hilt (1993), how Brilowski and Wendler (2005) gain the idea of positive consequences for patients in particular and also for nurses. However, one has to read Fealy (1995) closely to identify what evidence is being used by Brilowski and Wendler (2005), and one has to assume the evidence for positive consequences is found on Fealy (1995) pg 1136 where it indicates the potential for reciprocity in the giving and receiving of care, as no other part of the article indicates any consequences of caring.

Brilowski and Wendler (2005) go on to argue that the most important outcome for the patients is that of a nurse caring resulting in increased health and healing. This is well supported in their literature sample with reference to eight articles (Fowler 1989, Gino 1998, Halldorsdottir and Hamrin 1997, Hartman 1998, Hartrick 1997, Hinds 1988, Pearson et al. 1997, Wing 1999) to support their statement. Similarly, Brilowski and Wendler (2005) use nine articles (Beck 1991, Francis 1988, Fredriksson 1999, Funk 1992, Gullo 1998, Halldorsdottir and Hamrin 1997, Mallory 1988, Owen-Mills 1995b, Pryds-Jensen et al. 1993) to conclude that caring results in a sense of solidarity, empowerment, comfort, hope, increased reality and self-esteem, security and personal growth.

What Brilowski and Wendler (2005) do not make clear is whether these results apply to patients, nurses or both groups. One has to assume these results of caring apply to both nurses and patients, as Halldorsdottir and Hamrin's (1997) research is on patients' perspectives of caring, whilst Pryds-Jensen et al. (1993) and Fredriksson (1999) investigate the nurse's perspective, with Owen-Mills (1995a) exploring the role education has in developing caring nurses. Brilowski and Wendler (2005) then specifically state that for patients, caring results in a lessening of fear and anxiety, thus one suggests the previous results were referring to nurses and patients.

Brilowski and Wendler (2005) suggest that caring also influences how patients perceive a nurse. Again one identifies that Brilowski and Wendler (2005) are less than rigorous in their support for their arguments. They note from Halldorsdottir and Hamrin's (1997) research, that a nurse is seen as compassionate, respectful, competent and concerned, however, they do not identify how they reach this conclusion using Halldorsdottir and

Hamrin's results. Similarly, one has to work hard to decipher where Brilowski and Wendler (2005) draw their conclusions from in the work of Crigger (1997), Hartrick (1997) and Oulton (1997) to support their argument that the nurse is influenced by the experience of caring, gaining tolerance, personal and professional satisfaction in caring. One feels that a major point such as this really requires Brilowski and Wendler (2005) to support it with greater use of research literature to maintain it as a creditable statement. Brilowski and Wendler (2005) then suggest that through caring the nurse is more able to understand the illness experience. Again they only use one source of evidence (Baker and Dieckelmann 1994) but one suggests two other articles, Hartman (1998) and Fredriksson (1999) support this point and one remains puzzled by Brilowski and Wendler's (2005) lack of rigour in support of their argument.

The final consequence of caring, for the nurse, Brilowski and Wendler (2005) suggest is that it provides the nurse with a position of strength in the health economy, as caring is a desired product of healthcare. This argument is supported using Tuck et al's (2000) research on 16 U.S hospitals philosophies on nursing. However, one suggests the Brilowski and Wendler (2005) have misinterpreted Tuck et al's (2000) paper as the original phrase is seen to be 'advantage goes to providers who can provide high quality care and still remain profitable' (p183). One proposes that it is naïve to suggest that the nurse is the focus of this statement, rather than the organisation. Tuck et al's (2000) notion of care in this phrase seems more likely to be that of procedural and task based nursing rather than the emotional/affective nursing care that Brilowski and Wendler (2005) are analysing.

Having completed the identification of antecedents and consequences of caring, Brilowski and Wendler (2005) move on to briefly mention the idea of related concepts. They identify several of these related concepts as nurturing, compassion, concern and ministering, supporting this identification by using four articles (Boykin et al. 1994, Crigger 1997, Oulton 1997, Young-Mason 1991). Brilowski and Wendler (2005) seem to imply there are further related concepts as they use the term ‘include’ prior to listing their selected ones. Brilowski and Wendler (2005) then state that these four identified related concepts were mentioned only once and do not comment on which article includes which related concept, nor whether each related concept appears in more than one article.

For example, on reviewing the primary source of Crigger (1997) one finds the use of ministering as a definition of nursing care in Crigger’s (1997) first criticism of the ethic of caring. However, one notes that Crigger (1997) is in fact citing this definition from another source to illustrate the criticism, and in fact is arguing that ‘to minister to a person is the usage of traditional nursing’ (p218). Thus again one can suggest that Brilowski and Wendler (2005) are making interpretations of the articles that cannot readily be substantiated, and one wonders what other related concepts exist that have not been included.

To support the notion of related concepts Brilowski and Wendler (2005) note that all those identified were embedded in the wider discussion of caring – as was seen in Crigger (1997) – and Brilowski and Wendler (2005) argue this embedded-ness illustrates the relatedness of the concepts. One wonders if Brilowski and Wendler (2005) have

fallen into the trap of using care and caring synonymously, a criticism levelled, by Paley (2001) at nurses trying to define the concept of caring.

Moving onto the discussion of the concept analysis, Brilowski and Wendler (2005) reiterate that their review of the literature covered the 14 years between the keyword 'caring' appearing in CINAHL and the year 2002 and state that five attributes, along with antecedents, consequences and related concepts were identified from the literature sample. They continue by describing the range of articles that described caring; ranging from 'simple stories of exquisitely orchestrated episodes of physical care between the patient and nurse' (p646) to the rigorous research studies that define and describe professional nurse caring characteristics.

Brilowski and Wendler (2005) end their discussion by noting that paradoxically as the concept developed in complexity the articles reviewed contained fewer specific definitions of the concept. Again one notes that Brilowski and Wendler (2005) may be using terms synonymously as they identify that earlier articles often contain a clear definition of *nursing*, whereas what Brilowski and Wendler (2005) profess to be undertaking was an analysis of *caring*. One proposes that by doing this Brilowski and Wendler (2005) are suggesting that caring equals nursing, rather than seeing caring as one of several integral parts of the process of nursing.

Following Brilowski and Wendler's (2005) discussion, they go on to complete the final stage of evolutionary concept analysis as defined in Rodgers (1989, 2000a, 2000b) approach. This entails application and use of the concept analysis in a real world case, either through qualitative research or emerging from a practice situation.

Brilowski and Wendler (2005) choose to use as an exemplar, a caring experience of the first author Brilowski. One is not informed of when this experience occurred, so one is unable to establish whether hindsight and new knowledge, gained by Brilowski, since the experience have affected the application of the concept analysis. Brilowski and Wendler (2005) also do not indicate if the nurse referred to in the scenario is Brilowski or whether Brilowski had just observed the scenario occurring. One argues that this is crucial to the application of the concept analysis, because if the nurse was not Brilowski, then Brilowski and Wendler (2005) have placed their interpretation of caring onto the scenario. The nurse concerned may not have been caring using the same interpretation and thus Brilowski and Wendler's (2005) application may be flawed. No conclusions are drawn from their application of the concept analysis, again leaving one to either concur or disagree with the application.

Continuing, Brilowski and Wendler (2005) identify the implications of the concept analysis for nursing pointing out that in their concept analysis there is an obvious need for more theory development and research. One suggests that Brilowski and Wendler (2005) fall in to the same trap as other authors, by arguing that their work identifies important indicators for developing a definition through further research, rather than proposing a definition for caring. This was a major criticism of the nursing profession levelled by Paley (2001).

One is disappointed that Brilowski and Wendler (2005) did not feel confident enough in the evolutionary concept analysis to maintain a defence of their results by strongly stating their views and offering a definition. Limitations of the concept analysis are noted by Brilowski and Wendler (2005) to include problems of sampling which may

have excluded some seminal works. One would suggest that through their sampling approach Brilowski and Wendler (2005) missed a seminal piece of work, that by Morse et al.'s (1990), who were the first to attempt an analysis of the concept. This lack of Morse et al.'s (1990) work from the sample has meant Brilowski and Wendler (2005) missed an opportunity to identify similarities between their attributes and the categories defined by Morse et al. (1990). One argues that if they done this Brilowski and Wendler (2005) could have made a definitive statement regarding the attributes of caring and thus moved the debate forward, allowing these attributes to be investigated through further research.

What Brilowski and Wendler (2005) do argue is that the identified antecedents allow nurses to address factors that might hinder them from caring, such as the environment; and also that the consequences provide outcome criteria for assessing caring in practice. One queries the latter conclusion as the consequences identified by Brilowski and Wendler (2005) are complex and difficult to measure in a way that is reliable and not excessively time consuming. Brilowski and Wendler (2005) further suggest that the identified attributes could be used as a method of student evaluation, and that the attributes, antecedents, consequences, related concepts and exemplar could be used to help nursing students to understand the core features of nursing care.

Brilowski and Wendler (2005) then include a short summary which identifies what is already known about the topic of caring, and indicate that care and caring are used in the literature as if the core attributes are already defined and known, however, they argue caring is a ubiquitous concept in nursing and remains ambiguous.



One suggests this is not a new conclusion, as it has been clearly identified previously by many authors, including Morse et al. (1990), McCance et al (1997) , Lea and Watson (1996) and Lea et al (1998). Indeed, Paley (2001) notes that this is the only consistent conclusion nursing has reached regarding caring. It is at this point that Brilowski and Wendler (2005) could have clearly stated their definition of caring.

Finally Brilowski and Wendler (2005) state that there are no published concept analysis of caring in the nursing literature. One disputes this point, as Morse et al. (1990) although not calling their work a concept analysis have arguably undertaken and published one, as indeed has Sourial (1997) who used Walker and Avant's concept analysis approach to undertake an analysis of caring.

Finally a short conclusion is offered by Brilowski and Wendler (2005) that summarises the five core attributes of caring – relationship, action, attitude, acceptance and variability. Antecedents that are required for caring and consequences of caring for nurses and patients are then reiterated. Brilowski and Wendler (2005) finish by stating their findings add to the body of knowledge but also give an important impetus for further theory development and research in nursing.

### **Summary of main points relevant to the thesis**

Emerging from this section of literature review on the concept of care in nursing are several aspects of caring that require further investigation through the literature. These aspects can be grouped into themes relating to the nurse, the patient and the organisation. Firstly aspects of nurse's autonomy in caring and the nurse's philosophy of care are identified. Issues of whether nurses perceive they have gained autonomy in their

delivery of patient care and what they perceive the care to be emerged as a gap in the literature. With this was identified the issue of nurses appearing not use the same caring approaches with all patients and this notion of variability in caring may gain more focus from this thesis.

The use of a philosophic base to nursing will be explored in the research and will encompass the professional socialisation of nurses and question whether nurses have a shared conceptualisation of care. Embedded within this will be the notion of the effect of educational processes on nurses' caring behaviours which may prove significant for this thesis.

Secondly, knowledge of the patient's involvement and experiences of care from the patient perspective are noted as being lacking in the literature. This research will establish and give further consideration to the patient's experiences of care. Several issues emerged from the literature that suggest that it is questionable whether the patient's experience of care has altered through time, and this current research may highlight issues that remain for patients' experiencing acute care.

The issue of moral development in terms of both the patient and the nurse may affect the patient's experiences of care and therefore may be important in the proposed research along with the notion of mutual acceptance, and a particular disposition for nursing may all be crucial to explaining the patient's experience of care in the thesis. This thesis will allow comparison between the patient's definitions of care boundaries and experiences, with those of the nurses, to identify whether these are congruent.

The issue of the importance of the nurse-patient relationship emerges as a recurrent theme from the literature and one suggests that, given the previous positive emphasis placed on the nurse – patient interaction in terms of caring in nursing; this is a crucial aspect of the patient experience that requires further exploration in this thesis.

Finally the organisational context of care adds new elements to the concept of caring in nursing that require investigation. In particular aspects of economics, workload, organisational theories and socialisation of nurses which have implications for the profession in trying to characterize its role and boundaries within a continually changing health care environment need explored. From the literature brief mention was made of constraints on time, increased technological demands, unattractive patient characteristics and lack of incentives to care which may all impact on the patient's experience of care.

The initial review of the literature on the concept of caring offers some understanding of the complexities and interrelationships that exist in nursing within organisations. This will inform the data analysis and allow discussion of the results of the research. Some literature already exists in relation to the areas of patient's and nurses' perspectives of care, the nurse-patient relationship and organisational effects on caring and these will be reviewed in the following chapter to ensure aspects of the literature relevant to the research have been addressed.

## **CHAPTER 3**

### **PERSPECTIVES OF CARING A LITERATURE REVIEW**

#### **Introduction**

Having reviewed the literature in relation to defining the concept of caring in nursing, this chapter addresses the literature that explores different perspectives of caring. This will allow identification of the various factors that influence the care experience and will inform the research process.

Firstly, the literature on patients' perspectives of care will be reviewed; this literature is drawn from research in all care sectors which allows the contexts of care to be explored. Following this, nurses' perceptions of the process of caring are examined with emphasis on the practice of caring rather than the theoretical debate. Thirdly, issues relating to the nurse-patient relationship are explored and finally the literature relating to organisational factors that affect caring is reviewed.

#### **The patients' perspectives of care.**

Gaining an understanding of patients' perceptions of what aspects of care are important is fundamental in developing a framework of themes that allow exploration of a patient's experience of care. The last 10 years has seen a proliferation of literature and research that encourages patients to express their views on the nature of the care they have received (Attree 2001a, Fosbinder 1994, Irurita 1996, Koch et al. 1995, Leske J 2004,

Schmidt L A 2003, Suhonen 2007, Suhonen et al. 2002, Webb and Hope 1995). Contrary to the emphasis placed, by major Government reports, on the need for quality physical care (Davis et al. 1999, Department of Health 2001b, Health Advisory Service 2000 1998, Jarvie et al. 2006, Nursing and Midwifery Advisory Committee 2001a) the main emphasis, identified by these studies, is on the affective aspects of nursing care, rather than the technical aspects.

Webb and Hope (1995) in an exploration of the kind of nurses patients want, identified that there was no consensus, in the literature at that time, between staff and patients about what was most important to the patients. Indeed, they note that patients, until recently, appear not to have been consulted regarding the care they received, rather than the professionals promote modes of nursing that they judge to be most important. To counteract this lack of consultation, they undertook a quantitative study, using structured interviews, to establish which nursing activities patients rated as most important. Presented with a list of 12 nursing activities, the 3 top ranking activities were identified as 1) listening to patients' worries, 2) pain relief, and 3) teaching patients. Using a set of photographs they also attempted to elicit the patient's preferred type of nurse, and the preferred approach used by the nurse. The researchers were surprised to discover that patients chose their preferred nurse by attempting to assess, from the photograph, how sympathetic and kind they appeared to be rather than by their 'professional' appearance. A similar dichotomy was identified when a substantial minority, across all age groups, indicated that patient surnames and title should be used rather than first names, when shown photographs of various ages/genders of patients. However, 95% of the sample

indicated they themselves, preferred to be addressed by their first name. This result could, however, have been influenced by the sample group's perception of what the ward culture was in relation to using first names and from a desire not to be seen as different from that culture. An important issue here is how these perceptions of preference have been decided by the sample, and what has influenced their decision in terms of the specific attributes they have chosen as being appropriate for nurses.

Working in the same year, Koch et al (1995) published results of a study that specifically tried to access older people's experiences of nursing care in acute care of older people settings. Using existential phenomenology and philosophical hermeneutics as an interpretative framework, they identify emerging themes from the patients' stories. These themes are as follows: routine geriatric style care as exemplified by lack of attention, privacy and information, along with feeling powerless to influence their care and unable to express individual needs, care deprivation that appeared to be encouraged by rigid adherence to the rules of the organization allowing no choice or individualized care to be offered, and compounded by apparent lack of knowledge on the part of the staff, and depersonalization where patients felt treated with a lack of regard and lack of attention in terms of listening to them and their concerns as individuals, and of not being taken seriously.

A final theme of geriatric segregation was also apparent which the patients in the sample responded to negatively as their perception was not of themselves as elderly people. These themes, along with those from Webb and Hope (1995) begin to suggest the

experience of care is linked to the more affective aspects of nursing and as such take in aspects of culture, values and beliefs that may not previously have been recognized.

Irurita (1996) as part of a large piece of research undertaken in Australia, using grounded theory, identifies major categories related to aspects of care that appeared in the patient data but not in the nursing data. As the work was undertaken in Australia the descriptive language used differs from the previously discussed work. However, by inference the same themes seem to be apparent. Irurita (1996) suggests that the transition from person to patient involves a threat to that person's integrity; in this case, integrity being the ability to have control over one's life, maintain dignity and be an individual. The patient's perspective of this process is, then, one of vulnerability, (and an issue of 'labelling' in terms of the transition from 'person' to 'patient' becomes apparent). Three levels of vulnerability are suggested which relate to perceived risk to integrity and degree of control. Factors that affected level of vulnerability are offered in relation to illness, dependence, age and physical frailty, power imbalance, lack of information and loss of identity. These factors can quite clearly be seen to reflect those identified by Koch et al (1995) in terms of the patient's perceptions of care. Quality nursing care was identified as involving the process of preserving integrity, which has a patient role and nurse's role within it, although, according to Irurita (1996) the nurse's role is much more salient than the patients. She does not explore why this is but arguable it could be to do with the effect of power within the nurse's role.

To preserve integrity, the study identifies three main patient behaviours: "knowing what to expect and knowing the nurses", "contributing to care" which includes the

requirement of actively trying to recover, and finally “eliciting a nursing presence” – in other words taking actions to gain interaction with the nurses. All three of these phases involve the development of an effective nurse-patient relationship. The very placing of the term ‘nurse’ first and ‘patient’ second in the literature on nurse-patient relationships could be argued to place a greater emphasis on the role of the nurse in developing and maintaining the relationship than the patient. It could also indicate a perceived level of control or power over the patient, thus affecting the patient’s perception of the nursing care they receive. Power relationships will be explored in this research.

This emphasis on the interaction between nurse and patient, and the lack of patient’s perceptions of care is also addressed by Fosbinder (1994) working in the United States of America (USA). She established that, from the patient’s perspective, there are four characteristics of nurse’s interactive styles that are important. These are the processes of ‘translating’, ‘getting to know you’, ‘establishing trust’ and ‘going the extra mile’. Again the cultural use of language makes direct comparison problematic, however, translating appears to equate to Irurita’s (1996) notion of “knowing” and Webb and Hope’s (1995) “listening to patient’s worries’. Similarly the counter behaviour of depersonalization identified by Koch et al (1995) would match this term.

The components of translating include informing, explaining, instructing and teaching, with patients identifying the importance of this process. However, in this study the patients did not equate this process with any relationship to the quality of the care they received, unlike Irurita’s (1996) sample who clearly saw the process as playing a major



role in preserving their personal integrity, and thus impacting on their perception of the care given by nurses.

Fosbinder's (1994) second theme, that of 'getting to know you' seemed of great significance and importance to her sample evidenced by the amount of discussion and example given in the paper. However, there is less evidence of the importance of extensive personal disclosure on the part of the nurse in other work. (Irurita 1996, Irurita and Williams 2001, Koch et al. 1995, Hallstrom and Elander 2001, Attree 2001a, Webb and Hope 1995) The use of a friendly approachable style, along with patients being treated with respect, treated as an individual and wanting human interaction, however, do appear as important issues in these studies. This may well reflect a cultural difference of expectation, in terms the patients and nurses relationships, with early sharing of detailed personal information being much more of a societal and cultural norm in America.

This lack of major emphasis, from patients, on what might be described as a 'therapeutic-type' relationship throws into question one of the main ideological bases of what Salvage (1990) terms 'new nursing'. It raises the issue of whether patients want or require one to one relationships with individual nurses or whether they, in fact, want some form of relationship with nurses as a global group whereby they (the patient) are recognized as being an autonomous individual, but do not extend that same recognition of individuality to the people who are caring for them.

Redfern and Norman's (1999b) study indicates that only some patients recognized that the development of a relationship was a two way process. Linked to the development of a caring relationship is the issue of patients feeling able to trust and be confident about

the nurses involved in their care. This theme of trust is clearly specified by patients (Fosbinder 1994, Attree 2001a, Mattiasson and Hemberg 1998, Nordgren and Fridlund 2001) as a main element to perceiving care as good quality. The aspects of a nurse's behaviour that appeared to encourage confidence and trust for patients were specifically identified by Fosbinder (1994) as 'being in charge', 'anticipating needs', 'being prompt', 'following through' and 'enjoying the job'. Similarly Attree (2001a), working in the United Kingdom, established that having needs anticipated and help offered willingly instilled a feeling of trust in the nurses although the element of 'being in charge' which related to nurses knowing what they are doing was not apparent in her work. This could be, as Webb and Hope (1995) suggest, because good technical care has become a basic expectation in the National Health Service and, therefore, not deemed, by the patients, as worthy of comment. Potentially it is of greater importance to patients in the USA and therefore, they identify it as an important aspect of trust and confidence. However, the context of the care environment is important in relation to the research, particularly if the study was based in a Medic-Aid hospital, unfortunately Fosbinder (1994) does not state this and therefore the results cannot be generalised.

However, Nordgren and Fridlund (2001), working in Sweden exploring patients perceptions of self-determination, also identify competence of nursing staff as being of relevance to trusting the care provided. Redfern and Norman (1999b) also allude to the notion of patients expecting nurses to know what they are doing in several of their 'theme clusters'. They substantiate the idea of being prompt in response to patients needs and, also the idea of 'following through' which their sample describe as 'nurses kept their promises; they remembered to follow up requests' (page 416). A highly

significant theme from their study was that of motivation to nurse, which also appears to reflect Fosbinder's (1994) 'enjoying the job'. However, it is important to note that in their study this theme emerged principally from the nurses' responses rather than the patients. Similarly Attree's (2001a) results indicated positive comments about nurses who were cheerful, happy and smiling, which could indicate they were enjoying the job. It could be argued from these results that nurses' attitudes to their work of caring for patients is of great significance in terms of patients' perceptions of what nurses should be like, and therefore, could affect their experiences of care.

An interesting result is revealed in relation to trust and confidence in Nordgren and Fridlund (2001) study. The participants, as long as they trusted in the care they were receiving, did not feel the need to take the initiative but surrendered themselves to the care, retaining the traditional passive patient role. This may be because they also indicated that they felt powerless, and felt they had to accept rather than question the care they were given. This type of situation was also referred to by Koch et al.(1995) where patients did not feel they had a voice in their care and the organisational and contextual aspects of care impacted on their experiences.

Fosbinder's (1994) final category was identified as 'going the extra mile' reflecting nurses who provided care beyond the minimum expected – nurses who did more. Irurita's (1996) category of 'eliciting a nursing presence' reflects this theme as does Attree's (2001a) identification of care practitioners who were available, acceptable and approachable.

Early work in the area of patients' perspectives by Webb and Hope (1995) give an indication of one of the main themes emerging from the literature, that of listening to the patient. As they used a quantitative approach with pre-defined nursing activities, a less than optimal view of the patient's perspective may have resulted. However, this theme appears throughout Koch et al.(1995) study as well as in Fosbinder's (1994) theory of interpersonal competence and Irurita's (1996) theory of preserving patient integrity, all of which used qualitative methods to gain their results. Later work by Redfern and Norman (1999a, 1999b) using critical incident technique also supports the emergence of this theme as a main strand in patients' perceptions of their care.

The themes that emerge from the literature in terms of importance to the patient are: the concept of knowing the individual; in particular listening to what they want and think, listening to their experiences and showing respect for their rights, dignity and privacy, the issue of powerlessness; professionals using knowledge as power, and finally, the nature of the relationship with the nurse.

These themes emphasise the process of care undertaken by the nurses, albeit from the patients' perspective. What is still unclear is from where the patients derive these expectations of care, and what they see as the main obstacles to achieving the nursing care that match their expectations. This will be explored in the thesis.

### **Nurses' perceptions of the process of caring**

Concurrent with the intensive drive by nurse theorists (Leininger 1978, Orem 1985, Watson 1985) to define the role of caring as central to nursing, nurses' perceptions and experiences of caring have also been a focus for research. This move to try and define

the core activity of nursing coincided with the nursing profession attempting to confirm its status as a profession. This along with the rise of the feminist movement led to curricular changes that moved the focus of nursing away from purely technical and practical aspects of nursing towards a more holistic approach to care of patients reflecting the notion of nursing as an art and a science (Patistea 1999, White 2002, Wilkes and Wallis 1998, Tarlier 2004).

There is on-going theoretical discussion within the global nursing profession in relation to the meaning of caring and its centrality for nursing. Authors conducting this debate include Leininger (1985), Valentine (1989, 1991) , Morse et al (1991, 1990), Morrison (1991), Jacques (1993), Lea et al (1996, 1998), Krebs (2001) and Tarlier (2004) to name but a few. A lack of consensus and clarity about the concept of ‘caring’ persists within the academic debate; however, one suggests this debate is divorced from nursing practice as it is being conducted by nurse academics without reference to nurses working in the care sector. Therefore, the reality of nurses’ perceptions and behaviours is arguably of more importance to nurses and recipients of care than a definitive agreement as to what caring is (Kapborg and Bertero 2003).

In an attempt to understand nursing practitioners’ experiences of caring Astrom et al. (1995) working in Scandinavia, examined skilled nurses’ experiences of caring. By using interviews with three groups of nurses (n=15) from medical, surgical and long term care of elderly wards, attempts were made to establish similarities and differences within nurses’ perceptions of the caring role. The data revealed that ‘understanding the situation’, ‘establishing contact’ and ‘acting in the patients’ best interests’ were similar themes from all nurse groups. This latter theme, of acting in the patient’s best interests,

was, however, defined by the nurse's interpretation rather than the patients. This result is again reflected by nurses in Draper's (1996) study who justified their care decisions arguing that the decision is based on them being for the greater good of the patient, even if that was contrary to the patients wishes.

A major difference that emerged from Astrom et al.(1995) was that nurses in long-term care emphasised the caring focus to be support of the patients' psychosocial needs rather than that of the patients' physical functioning, whereas surgical and medical care areas emphasised the physical care needs. This result, in itself suggests that variations in the context of care may have an impact on the patient's experiences of care, and justifies the use of different sample areas for data collection when undertaking further research in this area.

An interesting result from this study was that all nurses got satisfaction and pleasure from delivering care and that this made the job of caring worthwhile. Nurses in the study identified the need for positive co-operation from other health care professions and patients' families to allow them to continue to maintain the caring role. This issue of being valued and supported requires further investigation, through this researcher's study, to establish whether being valued and supported effects the ability to continue caring.

When investigating quality of life issues Draper (1996) discovered, through ethnographic interview, that nurses perceived the proper goal of nursing care to be 'individualised' care and freedom of choice for patients. He established, however, that although all nurses espoused this principle of care, a conflict was apparent between nurses' expressed beliefs and their actual caring actions. Many of his sample (n=11)

were aware of this paradox and attempted to justify and explain it, often in terms of altruism. However, one respondent argued that restricted choice and individuality was more a result of routine, with control and choice removed from patients as soon as they are admitted to hospital. She argued that nurses 'assume responsibility for their patients because they have an ethos of expertise which is strengthened through association with the medical profession' (pg 330). A similar point is raised by Tarlier (2004) who suggests that the issue of power within the nurse-patient relationship operates at a hidden level within caring and is used by nurses subconsciously in their caring role.

This subconscious ethos of care results in patients who question and desire autonomy of decision making being perceived by the nurses as threatening. A particularly important point raised by Draper (1996) is that the paradox that exists between nurses' professional care behaviours, and the notion of individualism instilled by their educational experiences is promulgated by the organisational context of care rather than by individual nurses. The organisational structures require patient goals to be shaped to fit those of the system to promote smooth running of the organisation. This process is mediated by the nurses through their behaviours, and results in a cost to the patients of loss of autonomy and increased vulnerability. It must be noted that Draper's (1996) work was undertaken in a long-term care setting and these results may not be reflected in acute care settings. However, the issue of vulnerability has been identified by Irurita (1996) in her work in Australia looking at the threat to patient integrity of the transition from person to patient. The whole issue of nurses' use of control, through choice and decision-making and organisational demand may be fundamental to developing an

understanding of older person's experiences of care and should, therefore, be explored as a theme within the research sample groups during interview.

According to Sourial (1997) caring requires a broader perspective than that of the individual patient or nurse and recommends that within a business-orientated bureaucratic health care system, delivery of physical care is better facilitated than affective care. This issue of the development of a business orientated care system will be addressed later in the literature review.

In ending her analysis of caring Sourial (1997) suggests that the alternative concept of 'holism' be preferable to that of caring, because caring appears to her to be part of holism and therefore, holistic nursing care is a more comprehensive concept. This challenge has apparently been ignored by the profession with no apparent development of this argument appearing in the literature on caring. This might be because the authors working on the concept of caring have become too entrenched in their viewpoints to alter or develop their direction towards holism, or they, like Morse (1992), Morse et al.(1992) and Morse et al.(1994) have taken a differing aspect to explore. It could also be that through the process of education the notion of holism is well embedded, through their education, in nurses as part of their care approach and therefore, the need to develop this concept has not been seen to be relevant to their on-going practice in nursing.

Earlier work by James (1992) suggested that organisation, which she sees as a component of caring, allows a balance between physical and emotional work by nature of the context within which care is carried out. She argues that in institutional settings the organisational framework needs to allow modification of routines if nurses are to



provide total patient care that reflects the needs of the individual. Interestingly, Tuck et al (2000) working in the United States, reviewed the organisational philosophies of sixteen hospitals and found caring, professionalism and individualism reflected in all of the philosophies, indicating that the notion of individualised care is recognised by the organisations. Similarly according to Bassett (2002) the notion of caring having both a hard (technical), and soft (emotional) aspect is important in terms of explaining what care behaviours might mean to nurses and also how they might affect nurses.

The balance between the technical (hard) and emotional (soft) dichotomy of caring is reflected in results from Williams's (1998) grounded theory study investigating Australian nurses' views on delivering high quality care. Her results indicated that the nurses' ability to deliver what they perceived as high quality care was determined by the context in which the nurses and patients were interacting. Dissatisfaction with their work was experienced when the nurses felt they did not deliver quality care. Quality care was identified as meeting both physical and psychosocial needs, and was deemed to be therapeutically effective. If only physical needs were met, or partially met the care was deemed therapeutically ineffective. A study by McQueen (1997) develops James's (1992) notion of emotional work in terms of the context of care. Using a qualitative methodology interviews were used to establish nurses', working in gynaecological wards, views of the significance of caring and emotional work. Findings indicated that nurses, whether addressing physical and/or psychological needs were drawn into a relationship with the patient, conceptualised as a professional friendship. The data indicated that, comparably to Astrom et al.(1995) and Williams (1998) nurses gained

satisfaction from this relationship and that feedback from patients enhanced the feelings of satisfaction and pride in their work. This fits with Watson's (1985) view of caring suggesting that emotions are central to the person and can sustain and motivate behaviour.

The contextual nature of the care situation for McQueen's (1997) study does not allow for generalisation to other surgical settings, however, certain responses can be proposed as common to all care settings. Empathy and understanding were identified as particularly important to this contextual setting, however, these aspects were also reflected in other authors work (Allan 2002, Dyson 1996, Idvall and Rooke 1998, Redfern and Norman 1999b, Wilkin and Slevin 2004, Williams 2001a) and therefore, it could be argued that in accord with McQueen (1997) this aspect of engagement with the patient relationship is relevant to all nurses.

Work carried out in Finland by Greenhalgh et al.(1998) comparing general and psychiatric nurse behaviours; using quantitative methodology and a recognised validated questionnaire tool (Care-Q), established that the nurses ranked similar aspects of care highly regardless of care context, one of these aspects being 'comforts' which is defined as providing emotional and physical support.

These results are disagreed with by Idvall and Rooke (1998) who researched Swedish surgical nurses' views on care using qualitative methods of focus groups. Their results identified two dimensions to nurses' views; those of pre-requisites regarded by nurses as essential to make good care possible, and elements of performance that described a set of activities between nurse and patient. Each dimension was identified as having several sub- categories, these the authors noted were not mutually exclusive but overlapping.

The pre-requisite identified by the nurses as most important was that of having an adequate number of nurses, with others reflecting aspects of the environment, knowledge, routines and attitudes. A more detailed analysis was performed in terms of the elements of performance, with the authors using Carper's four fundamental ways of knowing as a theoretical framework. Somewhat surprisingly, the pattern of aesthetics (the art of nursing which involves creativity and is specific and unique to individual nurses) was not found in Idvall and Rooke's (1998) analysis. The authors explain this by arguing that surgical nurses might find this aspect of care difficult and not of a high priority, aesthetics being illustrated by empathy, intuition and knowing unique details of the patients. It was suggested that patients undergoing surgery were not in the ward long enough for these relationships to occur. An alternative explanation might be that this result reflects a cultural bias, as surgical nursing in Sweden is noted by Idvall and Rooke (1998) to focus specifically on practical and technical activities of care such as carrying out prescribed care and detecting and acting on signs and symptoms. This cultural determination was also reflected in Holroyd et al.'s (1998) research into patients' views of nursing care, where affective values were not present in their results. They argue that again this may reflect cultural undervaluing of these aspects of care, or that these aspects were absent from the nursing behaviour and thus patients were unable to identify them. Given that conflicting results are occurring in the literature further strengthens the need to explore this aspect of the context of care through using different sample areas. A further study researching nurses' perceptions of care work was undertaken by Williams (1998) in Australia using grounded theory. Actions and interactions attributed by nurses' to quality care, and can be seen to reflect the elements of performance noted

by Idvall and Rooke (1998) were examined and factors that inhibited or enhanced delivery of care were identified. Member checks and other researchers were used to confirm categories as the data was analysed as a means of improving credibility and veracity. However, the data was elicited from 10 semi-structured interviews undertaken by the author and 12 semi-structured interviews that were conducted by post-graduate students. The number of post-graduate students used is not noted. This use of other interviewers could have had a significant effect on the quality of the interview results and thus affect the data. However, as with the other studies the general theme of meeting patient's needs was identified (Astrom et al. 1995, Draper 1996, Greenhalgh et al. 1998, Idvall and Rooke 1998, McQueen 1997). The emphasis in Williams (1998) study was again the meeting of psychosocial needs rather than physical ones. An extra area, that of meeting extra care needs, those that were above and beyond the usual expectation of care, was identified by participants and seen as making the care delivered exemplary. This notion of meeting extra care needs was similarly identified in some of the work researching patients' perceptions of caring (Attree 2001a, Fosbinder 1994, Irurita 1996). Participants in Williams' (1998) study linked the context of caring with the ability of the nurse and patient to interact. The specific issue of available time was identified as crucial to high quality care, with quality being perceived by the nurses as diminishing when time was minimal or insufficient. Lack of physical and human resources also impacted on the availability of time for nursing care delivery. These results support those identified by Idvall and Rooke (1998) and are replicated in later studies (Allan 2002, Redfern and Norman 1999b, Skott and Eriksonn 2005, Wilkin and Slevin 2004). One argues, however, that it may be that the perception that time and resources has a

significant impact on the quality of care is influenced by the culture and context of care, where being seen to be 'doing' nursing care is legitimate work but more affective aspects of care that relate to psychosocial needs is not. This notion of caring as activities, that is 'doing' was identified by participants as 'real work' in Kapborg and Bertero (2003)'s study of Swedish student nurses. However, their results also suggested that student nurses incorporated involvement and interaction into their definitions of caring. It maybe that there is sufficient time for nurses to provide high quality care but because of organisational or peer influences it is used for other activities such as writing detailed nursing reports which do not directly impact on patient care but do meet organisational demands. Thus the issue of time can be a contested area in relation to caring and will be investigated in this research.

Although in Williams (1998) study nurses gained satisfaction and motivation from good care delivery, as previously indicated in Astrom et al.(1995) and McQueen (1997), they became stressed and dissatisfied with their work when they were not able to achieve this and felt their performance was being criticised by their peers. The effect of this was to reduce their positive attributes and competence and thus their ability to provide therapeutically effective care. Strategies were devised by the nurses to cope with these stresses, these ranged from focussing purely on certain needs, usually physical, to selecting certain patients with whom they had a conducive therapeutic relationship and focussing on them exclusively. Similar protective mechanisms used by nurses were discovered by Bassett (2002) and Redfern and Norman (1999a, 1999b) in their research. There is no discussion within Williams's (1998) research of how the selection processes were conducted by the nurses and it would be interesting to explore with nurses how

they identified and justified their actions using this approach to caring. It would appear that the nurse - patient relationship is important in this selection process and that potentially a system of favouritism is established by the nurses. There are inherent dangers within this method of coping, which are identified in work on the nurse-patient relationship undertaken by several authors, whereby nurses become too involved with the patient to the detriment of other patients, their colleagues and the organisation of work (May 1991, McQueen 2000, Ramos 1992).

The study by Williams (1998) was undertaken in Australia, where the context of care delivery is structured so that one nurse is entirely responsible for several patients, this may not reflect the current care context within the UK. However, with the introduction of the 'named nurse' driven by government policy in an effort to improve patient care, this care approach may become more common and would benefit from exploration in the research.

The nature of the methodological approach used by Williams (1998) does not allow for generalisation of the results per se.

However, a similar piece of exploratory, descriptive research, also using grounded theory methodology was undertaken in the UK by Attree (2001) where, through exploring and analysing key stakeholders descriptions of quality care, three sets of criteria emerged. As with other recent research (Idvall and Rooke 1998, Redfern and Norman 1999b, Williams 1998) care resources such as adequate staffing, appropriate staffing and enough time to care were clearly identified as affecting the ability to offer quality care, although Fagerstrom and Engberg (1998) would argue that an apposite number of staff is not a guarantee for good care.

However, variations in the emphasis placed on different aspects of resourcing were found between the different stakeholders and related to the sample groups differing priorities and roles within the organisation. Managers focused more on control, management and use of resources whilst the nurses emphasised the requirement for sufficient resources. These differing emphases within the organisational culture may in themselves affect the nurses' perceptions of their ability to offer high quality care. Similarly to results in Draper's (1996) work, a lack of understanding of the organisation's culture may lead to nurses being unable to reconcile their personal beliefs about quality care with those imposed on them by working within specific care contexts, thus resulting in delivery of poor nursing care. However, Dyson (1996) established that the care context had little impact on the work style of the nurse.

The care process was a second set of criteria emerging from Attree's (2001) work, with sub divisions into the nature of practice and nature of the practitioner. As with many other studies the nature of practice included undertaking fundamental care functions, as well as an emphasis being placed on psychosocial needs and communication (Astrom et al. 1995, Bassett 2002, Greenhalgh et al. 1998, Hegedus 1999, Idvall and Rooke 1998, Irurita and Williams 2001, Kapborg and Bertero 2003, McQueen 1997, Patistea 1999, Redfern and Norman 1999b, Skott and Eriksonn 2005, Williams 1998).

Similar to James's (1992) work, Attree's (2001) study also identifies organisation as a component of caring in relation to practitioners' methods of working. Good planning and management, as well as specific methods of organisation promoted quality care, although as previous studies identified, difficulties in organising care work related to

lack of staff, time and pressure of work (Idvall and Rooke 1998, Redfern and Norman 1999a, Redfern and Norman 1999b, Williams 1998).

The nature of the practitioner is identified in Attree's (2001) study as forming a major component of the nurses' responses; with emphasis being placed on 'caring' qualities such as being helpful, approachable and kind. A key factor expressed by participants was that concern was genuine and unconscious, not just done as part of the nurse's task, and it was suggested that this should be an integral aspect of the practitioners focus on caring. Furthermore, an essential element of the process of caring was the use of these qualities in developing genuine, reciprocal relationships with patients. This result is reiterated in work by Dyson (1996), Bassett (2002) and Godkin and Godkin (2004). Participants in Attree's (2001) research suggested positive caring relationships were developed through continuity of care, patient involvement and information sharing. However, Attree (2001) argues that caring is made difficult or obstructed by the absence of close social relationships; a view which is supported by Dyson (1996) who suggests that nurses' concept of caring, although enlightening does not necessarily match with their experiences in clinical settings and professional practice.

The final criterion established by Attree (2001) was care outcomes. From the nurse's perspective, as in other studies meeting patients' assessed care needs were given highest priority, closely followed by patient comfort, happiness and satisfaction (Bassett 2002, Greenhalgh et al. 1998, Idvall and Rooke 1998, Williams 1998). Patients progress to discharge assumed most importance to managers which again may reflect the organisations requirements as being paramount for them. This approach by managers



might conflict with the nurse's approach and thus cause tension and stress within the nurses' role of caring.

From the literature reviewed it can be seen that nurses see their main caring role as being to meet patients' care needs. Most studies identified the psychosocial and emotional aspects of the care work as being of greatest importance to the participants, although often caring was reported as being a combination of physical and psychosocial care. Several studies identified barriers that affected nurses' ability to care in the way they felt appropriate and this caused stress and dissatisfaction with their jobs. However, a major component of all the studies was the recurring theme of the nature of the relationship between the nurse and patient. This relationship was seen as pivotal to the nurse's care approach and requires further examination during the research study.

### **The nurse-patient relationship**

The nature of the relationship between the nurse and patient has assumed increasing relevance in the discussions on caring in nursing. Reference to this relationship occurs in the literature reviewing patients' and nurses' perceptions of care and is identified by nurses as being important in the caring situation.

In work published prior to 1991, researchers addressed the issues of nurse attitudes, patient attributes and the effect on the nurse-patient relationship and established that patient communication, expression of appreciation for care, ability to get on with others and a degree of similarity of values with the nurses all affected the relationship (Forrest 1989, Kahn and Steeves 1988).

Two researchers, May (1991) working in Scotland, and Morse (1991) in Canada published seminal articles on the nurse-patient relationship at the same time. Each sought to establish the basis of the nurse-patient relationship using taped semi-structured interviews and a grounded theory approach to the research. The sample groups were significantly different with Morse (1991) using eight differing clinical areas ranging from psychiatry through intensive care to home care, and a sample number of 44; some of whom were interviewed more than once, whilst May (1991) focussed specifically on surgical nurses and had a sample number of 22. Involvement was seen by May's (1991) participants to be a general quality of nursing work with the main fundamental feature being 'knowledge' about the patient, as this allowed the nurses to do their care work. Reciprocity and exchange of information was also acknowledged as part of involvement but remained bounded by the institutional expectations of appropriate behaviour within the nurse-patient relationship. A third feature of involvement was that of investment of clinical and managerial skills to meet the specific goals of nursing care. These three features are used by May (1991) to construct three models of nurse-patient relationship. Firstly, primary involvement is identified, which entails the nurse maintaining equilibrium between their private aspirations and the organisational role and goals. Primary involvement presents no problem to the delivery of care and organisation of nursing work and is seen to be patient-centred and beneficial to the nurse. A second model, which was demonstrative involvement, concerned over-reciprocity which led to nurse's having problems maintaining appropriate roles and affected delivery and organisation of care work on the ward. This model was nurse-orientated and could lead to stress and have implications for distribution of care to other patients.

The third model, associational involvement, occurred where reciprocity was rejected and investment emphasised, this model was seen to be organisationally orientated. May (1991) suggests that the excessive orientation to clinical practice and administrative work can result in alienation of patients, although the nurses see it as being in the best interests of the patients with distribution of care being unproblematic. In conclusion May (1991) offers these models as a contribution to understanding how nurse's values, beliefs and behaviours have effects on the nurse-patient relationship in practice.

Similar results are established by Morse (1991) who identifies two different types of relationships between nurses and patients. One, a mutual relationship formed by negotiation and interplay between the two participants, and containing four differing aspects that are circumstance dependent. The other is a unilateral relationship whereby one person is unable or unwilling to develop the relationship to the level desired by the other. These relationships are seen by Morse (1991) to have little to do with competence which she argues is inherent in the role of the nurse.

In defining the mutual relationship, Morse (1991) categorises four different levels of relationship defined by the level of involvement and intensity required.

Clinical relationships mainly occur with patients in for minor treatment, with contact with the nurse being brief. This relationship is superficial, courteous and undemanding of personal emotional involvement for either participant. From the patients perspective in this relationship nurses are interchangeable. Theoretical work by Crowe (2000) reiterates this view noting that the nurse –patient relationship does not rely upon individual subjectivity.

Therapeutic relationships are, according to Morse (1991), the majority of those that occur and arguably relate to her category of therapeutic intervention in the defining of the concept of care (Morse et al. 1990). These relationships are generally short lived with care given quickly and effectively. The nurse views the patient first in their role as patient and secondly as an individual with an external life. Similarly patients expect to be treated as patients and have a support system external to the hospital of friends and relatives who meet their psychosocial needs. For this therapeutic relationship to occur the patient needs to have confidence that the nurse will care for them appropriately. However, de Raeye (2002) suggests that initially the patient's trust is in the organisation and its representatives rather than in the nurse as a person and trust between people as individuals only emerges when information and knowledge is gained about each other.

The third style of relationship, according to Morse (1991) is that of connected relationships. In these relationships the nurse views the patient first as a person and then as a patient whilst maintaining a professional perspective on care. This relationship requires enough time to have evolved from a clinical or therapeutic relationship, or occurs because of the patient's extreme need due to their illness. In this relationship the patient trusts the nurse and the nurse chooses to enter the relationship and be the patient's advocate. The patients see the nurse as having 'gone an extra mile' for them respects the nurse's judgment and feels grateful for their care. The nurse in return feels they have made a difference to the patient.

The final mutual relationship is that of the over-involved relationship, and this is considered by Morse (1991) to be dysfunctional. These occur when the patient and nurse have spent long periods of time together and mutually respect, trust and care for each

other. The nurse commits to the patient as a person and this eradicates the nurse's professional beliefs and values. The patient relinquishes the patient role and the relationship continues beyond work hours. All commitment by the nurse to responsibilities for care of other patients, the organisation, treatment regime and care work is lost, and there is no objectivity which destroys the team approach to nursing care.

As with May's (1991) work these relationships were established through gaining of knowledge and reciprocity of information between nurse and patient. However, Morse (1991) goes further and delineates the ways in which nurses and patients decide to develop a relationship. According to Morse (1991) patients determine if the nurse is a good person and good nurse by asking others' views, then makes overtures of friendship and finally decides to trust the nurse. Similarly the nurse looks for a 'click' of personality, responds to the patient as a person, decides whether to facilitate a connected relationship, perseveres in her attempts regardless of the patient's response and gets to know the family.

Finally Morse (1991) indicates barriers to development of the nurse-patient relationship which include the issue of patient's viewing nurses as interchangeable and invisible; this particularly occurs in the clinical relationship. This issue is attributed to 12 hour shift patterns and irregular assignment of nurses to work with specific patients, this Morse (1991) suggests needs to be reviewed by nurses. However, Kelly (2005) proposes that even in emergency care, where time for patient contact is limited, there is the possibility of establishing a nurse-patient relationship.

A similar, exploratory study using unstructured interviews (2 per respondent) was undertaken by Ramos (1992) with a sample of 15 nurses from medical-surgical nursing. Unlike Morse (1991) she specifically excluded specialist areas such as psychiatry and paediatrics because these were considered to require specialised relationships that would affect the results. Results reflected those of May (1991) and Morse (1991) with participants describing a modified social relationship, the strength of the bond being variable depending on personalities of the participants. The relationships were seen to be reciprocal by the nurse participants but responsibility for maintaining the bond through regulating disclosure and controlling the direction was felt to be the nurse's role. By maintaining control of the relationship the nurses decided how much information was shared with the patient and their family.

Three levels of relationship were identified by Ramos (1992), a minimal instrumental level was formed which was relatively brief and superficial. This occurred when the patient was unconscious and the nurse did not know them, when the nurse was limited by the amount of time available to be with the patient, or when the patient's instrumental needs were so great that only necessary information was gleaned. When this sort of relationship occurred nurses described the outcome as non-productive, with insufficient nursing care and nurses indicated they suffered emotionally by being unable to care the way they felt was appropriate. This level could change with further verbal interaction and patient contact to becoming the second level – the protective level.

This protective level was controlled by the nurses, and was described as a unilateral connection, which reflects Morse's (1991) previous results. Although the nurses claim to understand the patient's situation, the behaviours they adopted were based on their own

values, beliefs and knowledge, and the assumption was made that the patient's wishes corresponded to those of the nurses. This relationship did not develop further if the nurse did not negotiate decisions with the patient or the patient lacked assertiveness. However, it could also progress to third level – the reciprocal relationship. According to Ramos (1992) this is a mutual relationship with strong cognitive and emotional bond between nurse and patient. Nurses found this relationship professionally rewarding and felt more useful, and this sort of relationship motivated the nurses to provide effective care.

Reflecting Morse's (1991) results, Ramos (1992) indicated that organisational constraints made this highest level of relationship difficult to achieve, with patients being 'sicker' and having shorter hospital stays. This caused the nurses to have a decreased satisfaction in their work.

Further work undertaken in Finland by Haggman-Laitila and Astedt-Kurki (1994) explored both patients and nurses expectations of the nurse – client interaction. A sample of 20 primary health care nurses and 100 patients, 60 from hospital care and 40 from primary care, were interviewed using a freeform thematic interview technique. One has to question why the patient sample contained both hospital and primary care participants whilst only primary care nurses were included in the nurse sample. This could affect the patient results found in this study as different personality of nurse may work in different areas of care. No information is given in the paper on the process of data analysis and therefore its veracity is not well established.

In exploring what was expected of nurses the patient participants indicated that nurses should treat all patients equally and as individuals, being genuine and honest. It was

expected by the patients that the nurse would ask their opinions, desires and views on the state of their health and was expected to assume overall responsibility for the patient's need for help and nursing care. However, patients noted that nurses treated all patients in the same impersonal way using a 'pattern' of approach for the interaction.

Nurses themselves expected to be able to deliver holistic, patient centred care with some considering the nurse-patient relationship to be essential. One suggests that, given the patients' views regarding impersonal care, the nurses' behaviours did not match their actions but this is not commented on by the authors.

Both sets of participants identified barriers to good nursing care that included a routine like attitude to the work and organisational tasks that took time away from the patients. Patients also noted that the hurried atmosphere in the wards prevented them from disturbing or bothering the nurses whom they perceived as being busy.

Discussing what was expected of the patients, Haggman-Laitila and Astedt-Kurki (1994) identify two categories of meaning. What is unclear is whether these categories were nurse or patient expectations although through interpretation of the writing it becomes clear that these were patient expectations. Some participants expected patients to be active, show initiative and be autonomous, thus being expected to want to recover or live with their illness. However, others expected them to be obedient and adaptable to the rules of the organisation and to be satisfied with the care given thus avoiding the label of a 'difficult' patient. Haggman-Laitila and Astedt-Kurki (1994) suggest that these descriptions reflected the role the patient participants had adopted. Nurses' expectations of patients were then identified, with patients being expected to accept nursing practice



but to also be committed to autonomy; however, they also accepted temporary dependence on the expert nurse, by the patient, due to illness.

In conclusion, Haggman-Laitila and Astedt-Kurki (1994) suggest patients' expectations were fairly concrete and described good interactive relationships which reflected diverse approaches. The nurses' very general and abstract description of the interactions appear, to Haggman-Laitila and Astedt-Kurki (1994), to suggest a lack of knowledge of the patients' experiences, or that the whole issue of the experience is taken for granted, and of limited interest to the nurses. Similarly Haggman-Laitila and Astedt-Kurki (1994) surmise that nurses do not really know what patients expect from them.

However, in relation to the role of the patient the more uniform expectations expressed by nurses and patients suggests that within the nursing culture the patient role entails unwritten norms that reflect the unwritten rules and regulations of the interaction. Haggman-Laitila and Astedt-Kurki (1994) suggest further research is required to establish which patient expectations are justified and on what grounds. One would suggest that in fact first one should establish what patients expect from nurses and what the patient's experiences of acute care are, to identify whether there is an issue with their expectations or not; and this current research will address their experiences.

Forchuk (1995) researching nurse-patient relationships with psychiatric nurses and patients established similar results and concluded that each nurse-patient relationship was unique and related to the individuals within the dyad. This implies that nurse – patient relationships within the psychiatric setting differ from those in acute care as Crowe (2000) suggests

“emphasis on predictability within the relationship ensures that both nurse and patient are replaceable; the relationship is not dependent upon the individual subjectivity of those involved but can be utilised by any nurse with any patient”  
(pg 965)

Similarly Ramos (1992) excluded psychiatric nurses from her sample, although Morse (1991) did not, thus perhaps Morse’s work may be less reliable in terms of its conclusions as the inclusion of psychiatric nurses may well have skewed the results in a significant way as the emphasis in psychiatric nursing is on a close therapeutic relationship that is arguably less important in the care of patients’ with physical ill-health.

Writing a theoretical treatise, McQueen (2000) confirms the results of these previous studies acknowledging the satisfaction that can be gained by the nurse in developing therapeutic relationships, but unless this occurs in a supportive environment burn-out can occur. McQueen (2000) maintains that the nurse-patient relationship illustrates the emotional work nurses are involved in when maintaining a reciprocally agreeable and therapeutic relationship. She argues that the hidden work of developing and maintaining these relationships should be acknowledged by the organisation, and attempts made to audit their effect on patient recovery time. Unless this occurs, she suggests that patient-focused care cannot become reality. However, what is still unclear is whether this aspect of their care is important to patients and this will be examined through the research.

Williams (2001a) suggests that patients might need and benefit from an intimate relationship with the nurse, however, her research focused on the nurse’s views of developing an intimate relationship. Using taped semi-structured interviews with 10 registered nurses from acute clinical settings in the UK, she established that nurses used

similar approaches to maintaining the nurse-patient relationship to those identified previously (May 1991, Morse 1991, Ramos 1992). The term and concept of intimacy was considered inappropriate by the participants in Williams (2001a) study. She argues that this is because this characteristic was considered by participants to be inappropriate within a professional relationship and reflected the perceived need to maintain an emotional distance between nurse and patient. However, as Irurita and Williams (2001) suggest, this emotional distancing is, of necessity, a survival mechanism for nurses to preserve their professional integrity within unfavourable work contexts. Thus it made it difficult to establish therapeutically effective relationships with patients.

In a theoretical article reviewing moral considerations in nursing, Nordvedt (2001) suggests that basic conditions for proper nursing care in the form of nurse-patient relationships are lacking due to scarcity of resources in today's health care contexts. This, he proposes, affects the professional nursing care offered by the nurse and threatens the quality of patient-centred care and argues that a minimum quality of professional and therapeutic relationships is of primary and fundamental importance to health care in general.

Similarly, Stickley and Freshwater (2002) in their academic paper suggest that lack of resources, in particular time, causes nurses to lose their ability to form a truly therapeutic relationship with their patients. They argue that this relationship is an essential component of nursing. A difficulty in this view point is that Stickley and Freshwater (2002) define the therapeutic relationship for nurses in the same manner as that pertaining to psychotherapy and counselling. This does not reflect the nature of the therapeutic relationship as defined by Morse (1991) and reiterated by others. One might

suggest that therein lies the difficulty for nursing as a profession, as the former type of relationship assumes and requires a long term time commitment to develop and sustain it, although this type of relationship might exist within the psychiatric arm of the nursing profession. However, as Moyle (2003) indicates in her phenomenological study with depressed patients, even within mental health settings this intensive type of nurse-patient relationship is lacking, although expected by the patients. It would seem that the terms nurse-patient relationship and therapeutic relationship have been used by the nursing profession as being synonymous, rather than discrete entities with differing perspectives and thus nursing is not homogeneous. Arguably this has led to nurses trying to achieve a time dependent therapeutic relationship with their patients rather than a nurse-patient relationship or responsive relationship as defined by Tarlier (2004). A responsive relationship encompasses the same attributes as Morse's (1991) therapeutic relationship, those of trust, respect and mutuality.

In summary, this literature suggests that nurses view a nurse-patient relationship as important in their ability to deliver nursing care. Difficulties may be being presented to the profession by the synonymous use of the terms nurse-patient relationship and therapeutic relationship and may be leading to frustration and stress for nurses who attempt to achieve the latter in an organisational system that precludes an adequate timescale for development of this type of relationship.

What is less well established is whether the relationship between the nurse and patient affects patient recovery time, is considered necessary by the patient and what the effect of the organization has on its development. These aspects of the relationship will be explored in this research.

## **Organisational factors**

The organisational system had been identified, in the previously discussed literature, as being a factor that influences the care experience. Literature relating to this area is limited and the majority of it pertains to nursing in the USA and Canada. Writing in this area became prolific in 2000, and appears to have been triggered by the introduction of 'magnet' hospital and changed healthcare financing. Its usefulness, therefore, may be limited due to the differing nature of health care provision between the USA and the UK. However, it allows a base line of information to be established in terms of knowledge relating to organisational factors influences on caring.

Milne and McWilliam (1996) undertook a phenomenological study in Canada, using 6 patients and 14 professionals, to increase understanding of nursing as a resource. Using observation, semi-structured interviewing and document analysis, and focusing on issues of values, intentions, needs, motives, work effort expectations and impediments, they established that the meaning of nursing as a resource was 'caring time'. 'Spending time' was the overarching concept that encompassed 'doing to/doing for' activities and which could also but not necessarily include 'being with'. The results of the study showed that the organization accorded 'being with' activities with patients as of less value than 'doing for' activities. This created tension for the participants as the time required for a connected nurse-patient relationship was overlooked when allocating nursing resource. This, Milne and McWilliams (1996) argue, is because efficiency-orientated bureaucratic hospitals value quantification of time as a distinct, objective and detached entity. Their study reveals that there are conflicting paradigms and values involved in working in an organization such as a hospital. They suggest that failure of the organization to develop a

‘corporate’ culture that recognizes and values caring in its totality is a serious threat to nursing and also the patient experience.

Concurring with this are results by Wiggins (1997) working in the UK, who used grounded theory methodology to investigate how surgical nurses coped with conflicting organisational, and professional demands. Her results showed nurses adopted various strategies to reduce the cognitive dissonance they experienced. Nurses used rationalization, acceptance, looking for good points in management initiatives and keeping the problem to themselves as a means of coping with the conflict induced by the contrasting philosophies. The discrepancies between the nurses actual care behaviours and those that they valued were blamed on the external demands of the organization in the form of Trust and nurse management. The nurses felt they had no ability to influence management aims and that lack of time, tight budgets, reduced staffing and increased technical care were indisputable facts. The main strategy of rationalization led to feelings of guilt for the nurses, and they saw the use of routinised care as a means of reducing the stress caused. This notion of routine as a means of reducing anxiety and stress is reiterated by Philpin (2002) who argues that rituals and routines allow the maintenance of social order through reinforcing cultural and social structures. One can therefore, argue that by using routinised care nurses are assisting the organisation to maintain a culture that the nurses themselves are not happy with. This will be explored in the research.

Other work by Latimer (1998) reflects this, with results suggesting that nurses’ practices are required to meet with criteria from varying different directions and this may involve them balancing contrary views because they are not performing to one professional

constructed domain. Latimer (1998) suggests the ward report is used by nurses as an organisational process through which they establish their own and patients identities to help produce a clinical domain. Similarly, Payne et al (2000), in an ethnographic study established that handovers fulfil a number of complex functions in guiding nursing care, one of which is to produce group cohesiveness amongst the nursing staff.

The organisational environment of a hospital is, Tummers, Godefridus et al (2002) suggest, one of uncertainty and complexity and this also creates a loss of control for nurses due to the imbalance between environmental demands and individual resources to cope with these demands. However, Ray, Turkel et al. (2002) note that if current practice is routinised most workers do not feel valued as individuals in their jobs. Similarly Gifford (2002) working in the USA concluded that bureaucratic organisational norms of hospitals including hierarchical structures, rules and regulations and great emphasis on measurement of outcomes and cost effectiveness is not a culture that enhances nurses job satisfaction as it does not embrace human relations cultural values.

Researching nursing organisational practice in the UK using a quantitative methodology and hierarchical cluster analysis, Adams et al (1998) show that current nursing practice does not fit the defined organisational ideals of functional, team or primary nursing and that ward working was a hybrid of the three ideals. They argue that the variable numbers and grades of nursing staff available for care work, along with unpredictable variations in workload militate against systems that require continuity of caregiver, and a stable small team, with similar results established by Norrish and Rundall (2001) in the USA and Lundgren and Segesten (2002) in Sweden.

However, Adams et al (1998) identified that three systems of ward working existed that related to authority and responsibility. The most common method of nursing organisation was that of two-tier nursing (76% of wards sampled), followed by centralised nursing (13%) and devolved nursing (11%). In the two-tier system nurses work in teams to provide care but a team leader is responsible for care plans and updating them, they also do doctors' rounds and receive information relating to patients from other health care professionals. Adams et al (1998) suggest that this system although similar to the ideal of team nursing differs due to various contrary characteristics such as having one large communal ward report on all patients, and that ward sisters retain a higher degree of control than in true team nursing. In centralized nursing, the power and control remains the remit of the ward sister, and has the lowest amount of team working, with no team leaders existing. Responsibility is jointly shared between any registered nurse, the nurse in charge of the ward and the ward sister. Devolved nursing involves team work but responsibility is clearly invested in each individual nurse. Care plans are updated by the appropriate nurse, who also accompanies the ward round for discussion of these patients. Large formal reports do not feature in this approach, and medications are dealt with by the individual nurse for the individual patients they are caring for. In terms of coping, nurses in the two-tier system felt least able to cope with ward workload, whilst those in the devolved group perceived themselves as better able to cope. Interestingly, the differing approaches had significant effect on nurses feeling of empowerment and value, with nurses in the two-tiered system feeling least valued, with lack of innovation and professional development opportunities. Those using devolved nursing perceived more opportunities for innovative practice and



good working relationships with managers and other professional groups. The different styles of nursing had no effect on the amount of influence nurses felt they had, but it did affect job satisfaction with nurses in the two-tier system experiencing least job satisfaction.

Adams et al (1998) conclude that two-tier nursing gives a duality in the wards attitude to sharing authority and responsibility which militates against collaboration, lowers the perceptions of standards of nursing practice achieved, prevents job satisfaction and amplifies nurses feelings of imbalance between resources and workload.

Theoretical work in America, by Norrish and Rundall (2001), looked at the effect of hospital restructuring on the work of registered nurses and on the satisfaction of nurses with their work. Norrish and Rundall (2001) noted that restructuring often reduced the emphasis on nurse-patient relationships and reemphasized team nursing. Nurses were found to spend more time on indirect care activities, such as care planning and administrative paperwork, and on technical direct care activities rather than providing care and comfort measures for patients.

Staff scheduling was also identified as an issue, whereby flexible shift patterns such as 12 hour shifts and self-scheduling were used to attempt to attract and retain staff. However, this caused difficulties in optimizing the staffing mix and caused dissatisfaction among staff when their expectations for scheduling were not met. Similar arguments regarding shift patterns and staff mix are identified by Bleich (2002). The dissatisfaction felt about their jobs resulted in nurses losing trust with the organisation.

The challenge of balancing the art and science of nursing within an economically driven organisation is explored in work by Turkel (2001). The study revealed that nurses were

struggling to maintain and preserve humanistic caring and nurse-patient relationships within a cost efficient service that was managed by others, and that they felt frustrated and fearful due to this. She suggests that the practice environment requires restructured to ensure maximum nursing time is focused on nurse-patient interactions, and that adequate staffing is available. Grounded theory research undertaken in the USA by Ray, Turkel et al. (2002) concurs with this and with Norrish and Rundall (2001) suggesting that loss of trust causes nurses to have decreased loyalty to the organisation and to become disillusioned with nursing practice.

Further work by Turkel and Ray (2004) confirms these ideas, noting that when organizations are permeated with considerate caring values they reflect a human face that is vital for self renewal. They argue that a culture that cares for nurses will allow nurses to convey their caring values to patients and relatives, thus improving patient care.

The organisational changes that occurred in the USA have to some extent been recently experienced in the UK healthcare system with multiple changes occurring in a relatively short time period. Williams (2005) suggest that although evidence based practice has been embraced by healthcare organizations, the integration of management research into hospital organisational systems has not followed suit and have resulted in a loss of trust between nurses and the organisation. Loss of trust and nurses wishing to be valued for their work was a recurring theme in several articles (Burke 2002, Johnston and Buelow 2003, Turkel 2001, Turkel and Ray 2004, Williams 2005, Laschinger et al. 2001, Adams et al. 1998).

Using quantitative survey methods, Williams (2005) explored the relationship between organisational trust and specific aspects of job satisfaction in nurses in the USA. She argues that the greater the inequity of relationship between the trustor and trustee the lower job satisfaction will be. Williams (2005) notes that nurse burn-out in stressful work environment can be mediated by improved job satisfaction. In her study organisational trust was significantly related to nurses' perceived value as professionals, autonomy, and collaboration and collegiality in professional interactions. Surprisingly, pay, and task requirements were not related to organisational trust but did contribute to job satisfaction for nurses. She suggests that addressing pay concerns will not be sufficient in terms of motivating the workforce but might neutralize the feelings of dissatisfaction. As with previous studies greater job satisfaction was linked with nurses having a sense of control of their work environment , and also control of their professional advancement (Tummers et al. 2002, Wiggins 1997). Williams (2005) concludes that trust is pivotal to creating organizations where individuals working in teams can respond willingly and rapidly to changing service demands, technology and other forces.

However, task requirements with an emphasis on the burden of paperwork and time available for patient care do contribute to poor job satisfaction (Bleich 2002, Williams 2005).

Nurse's relationships with paperwork seem to cause tensions in the work environment. Annandale (1996) using questionnaires and interviews explored nurses and midwives strategies to assist them to work in the new NHS. The research identified that nurses documented everything as a defensive strategy against organisation or colleague

criticism of the nursing care they had delivered. Similarly Allen (1998) established that nurses attitudes to the nursing records or care plans were ambiguous. The record was prized as a symbol of professionalism, however, its use as a means of protection from litigation were at odds with their professional values. Care plans were seen as superfluous and of little help to busy nurses in managing their workload. Seen as a drain on their already limited time, care plans were often left uncompleted. This ambivalence was compounded by the implications of accountability attached to care plans and nursing records, with nurses disillusioned by their belief that the plans contents and purpose had been twisted by consumerism and litigation. Allen (1998) concludes that although good record keeping is important to high quality nursing care it currently is used as an elaborate mechanism to defend hospital organisations against the courts. At the moment it offers little in terms of improved patient care, and is of little benefit to nurses, although the danger is that under organisational pressure the nurse will give priority to the nursing record rather than the less visible aspects of patient care. These views are supported by other research (Bleich 2002, Martin et al. 1999).

Moloney and Maggs (1999) established that emphasis in the documentation regarding clinical effectiveness, in one NHS Trust, focused more on the process of care planning and record keeping than on the actual patient outcomes. In undertaking a systematic review of the literature to establish whether care planning and record keeping had a measurable effect on patient outcomes, Moloney and Maggs (1999) were unable to include any studies in their review as none of their literature sample stood up to the rigorous tests applied for inclusion in the review. They concluded that there is no

evidence that the investment spent in education and training of nurses to use these documents has any effect on patient health status.

A recent interventional study in Finland by Karkkainen and Eriksson (2005) showed that following implementation of a new caring model and documentation, improvements were found in recording of the patients' experiences, with the collaborative planning and implementing of care with the patient being seen as the most important aspect of the records rather than the nurses actions. However, Karkkainen and Eriksson (2005) conclude that the nurses need strong support from their managers to implement these care plans, and that the managers vision of the goals of the documentation as means of securing good care, rather than a management tool to measure performed interventions was crucial.

Bleich (2002) also suggests that documentation and acts of charting are significant stressors for nurses, and are based on the previous shift patterns of working. These charts and documents, he suggests, need to change with a reduction of duplication and a system that is designed to reflect the core of nursing rather than one that has multiple disjointed and non-standardised forms that make interpretation a near impossibility.

It can be seen that various organisational factors affect nurses and their ability to deliver effective and satisfactory nursing care. The effects of the organisation on nurses' experiences of care will be explored through the semi-structured interviews in this research in order to establish how the systems affect the nurse's approaches to care work.

## **Summary of main points**

A review of the literature already in existence; in relation to the areas of patients' and nurses' perspectives of care, the nurse-patient relationship and organisational effects on caring, allowed the identification of several further aspects of the care experience that will be explored through the research.

Firstly, where patients derive their expectations of care from, and what they see as the main obstacles to achieving the nursing care that match their expectations, remains unclear. A further patient related issue; that of patient-focused care and its importance to patients is a further gap in knowledge relating to the patient's care experience.

Secondly, nurses, the relationships and interactions they have with patients and the influence it has on the patient experience still requires further exploration. The whole issue of power relationships and nurses' use of control, through choice and decision-making and organisational demand may be fundamental to developing an understanding of older person's experiences of care and will, therefore, be explored as a theme within the research sample groups during interview.

Similarly, what is less well established is whether the relationship between the nurse and patient affects patient recovery time, is considered necessary by the patient and what the effect of the organization has on its development. These aspects of the relationship will be explored in this research.

Finally, organisational issues that impact on care experiences were identified. It can be seen that various organisational factors affect nurses and their ability to deliver effective and satisfactory nursing care. Issues such as available time to care can be a contested area in relation to caring and will be investigated in this research. Similarly perceptions

that time and resources have a significant impact on the quality of care is influenced by the culture and context of care, where being seen to be 'doing' nursing care is legitimate work but more affective aspects of care that relate to psychosocial needs is not and this will be addressed in the research.

The effects of the organisation on nurses' experiences of care will be explored to establish how the systems affect the nurse's approaches to care work and whether by using routinised care nurses are assisting the organisation to maintain a culture that the nurses themselves are not happy with.

This review of further relevant literature highlights several aspects of the care experience that will benefit from greater investigation in this research.

## **Conclusion**

The central focus of this research is to gain an understanding of the older persons' experiences of acute care and to develop insights into how older people make sense of and explain their acute care experiences.

To inform and structure the research an extensive review of the literature relating to the concept of care in nursing, patients' and nurses' perceptions of care, the nurse-patient relationship and the organisational factors influencing care delivery has been undertaken. From this it becomes clear that the older patient's experiences of acute care and their understanding of that experience may be influenced by a complexity of factors which require further investigation.

A key message emerging from the literature review identifies that knowledge of patient involvement and experiences of care from the patient's perspective is lacking in the literature and older people's experiences and understanding of acute care remain largely unexplored.

Specific positive emphasis is given, in the reviewed literature, to the importance of the nurse – patient relationship and this is a crucial aspect of the patient experience that requires greater exploration as most of the previous research is from a nurse perspective. Issues of partnerships of care between older patients and the nurse with particular reference to decision-making, choice and care planning require further investigation to establish how older patient's construct and explain their experiences of care.

Further, the extent to which nurses values, beliefs and professional socialisation affects their ability to care, with a focus on establishing whether a shared philosophy of care exists, and how this relates to the older person's experience of care requires to be explored through the thesis to allow comparison between these and the patient's definitions of care boundaries and experiences.

Organisational issues that impact on care experiences have more recently become highlighted in the literature. The relationship between organisational working conditions and organisational demands, nurse's perceptions of their role in the organisation and the effect on the care experience need to be established in relation to the older person's experience of acute care.



The issues identified and substantiated through a rigorous review of the literature assisted in the development of the aims and key questions for the research. These are as follows:

Aims:

- To examine the experiences of older people within acute health care settings
- To examine qualified nurses' experiences in relation to older people, in the context of acute care
- To locate older people and nurse's experiences in the context of two organisational settings

Key questions:

- How do older people define themselves within the context of hospitalisation and society?
- What is the nature of the older person's interactions with nurses and what effect does it have on the person's recovery?
- How do nurses define themselves in relation to caring for older people?
- How do nurses define themselves with respect to their professional identity and socialisation within the organisational framework of acute care?

## **CHAPTER 4**

### **RESEARCH METHODS AND DESIGN**

#### **Introduction**

This chapter outlines the epistemological, theoretical and methodological values that underlie the methods chosen to answer the research questions identified in Chapter One. The research process is described and considered, and the relationship between the researcher and the research is also discussed. By doing this, the hope is to reduce assumptions that could be made within the processes of the research and make explicit the research decisions taken thus improving the rigour and validity of the work.

Previous research and audit has been undertaken, often in the form of governmental reports, which address some elements that are common to this study (Davies et al. 1999, Department of Health 1999, Department of Health 2001b, Health Advisory Service 2000 1998, Jarvie et al. 2006, Scottish Executive 2000, Scottish Executive 2005b, Scottish Executive 2005c). However, to the best of my knowledge no studies have addressed the specific aspects identified in the research questions stated on Page 146. This current thesis, as Parahoo (1997) acknowledges, does not start from a blank sheet but draws on and acknowledges previous accumulated knowledge of the subject of older people and their care experiences.

This study aims to investigate older people's experiences of acute care in order to gain an understanding of the effects interactions and participation in the world of acute care

have on the way older people make sense of their care experiences. In order to achieve this, the research study utilises a social constructionist philosophy.

Social constructionists, along with others using naturalistic (interpretative) inquiry, believe that knowledge and meaning cannot exist independently of people, but are conferred onto subjects and objects through human interaction and engagement in the world (Berg 2001, Crotty 1998, Lincoln and Guba 1985). Thus to investigate older people's experiences of acute care without acknowledging the meaning ascribed by them to the context in which they find themselves is to ignore a fundamental facet of their care experience.

A social constructionist position argues that behaviour is affected and shaped by social interaction and context, and also by issues of power and knowledge. All understanding stems from a view of the world from some viewpoint or other and reflects some interests rather than others. A critical position that challenges taken-for-granted ways of understanding the world is crucial to social constructionism whereby assumptions about how the world appears are challenged through an understanding of the influences of power and social context on the interactions that occur (Burr 2000, Open University 2008). In this research it is important to gain understanding of the social practices and interactions between older people and nurses in acute care. Similarly the differing constructions of the situation and the issues of power relationships in the social context of acute care need to be acknowledged. Thus the perspectives of older people and nurses must both be explored.

Berger and Luckmann (1991) discuss the processes by which social constructions become solidified into 'taken-for-granted' social order, however, each individual

encounters these as social facts to which they have to adjust. The perspective of social constructionism allows this researcher to explore the way in which the habits, institutions and characteristic ways of thinking of a social order; in this case acute care settings, is socially produced and explained by recipients of care as the natural and proper way of behaving.

In social constructionism the influence of the researcher cannot be ignored (Crotty 1998) and therefore there is an expectation that the researcher will impact upon the results of the study through their participation in data collection and analysis. Two aspects of the researcher's background have direct relevance. Firstly the researcher was previously a nurse and secondly the researcher's specialist area of practice was care of older people. Therefore this may influence the sample group response and also influence the interpretation of data.

People change their behaviour as a result of knowing they are being researched – the Hawthorne Effect (Clarke 1998). Similarly Oakley (2000) suggests that, as by definition, all research is an intrusion into a pre-existing system of relationships it is almost impossible not to change behaviour.

Social constructionists recognise and accept that the researcher affects the choice of research area, design, writing, analysis and outcomes, and they acknowledge there may be some areas of research that are more likely to form the focus of social constructionist research, notably those with multiple sectors and events, such as care situations. From one set of research, many different accounts of the same phenomena may be constructed that represent different researchers' views, experiences and multiple realities. Thus the

complexity of the context of acute care for older people would seem to require a social constructionist outlook as a framework for the research.

The theoretical framework for this research was influenced, not only by the social constructionist approach but also by the research questions. These had been identified through personal interest and experience in the area of study and also by a perceived gap in the current literature. In aiming to study the older person's experiences of acute care the research questions had to reflect the major relationships and contexts that the care occurred in, along with organisational aspects that may have impacted on the experience. The dynamic and complex nature of the research area suggests the need to adopt a framework of critical inquiry to establish the various perspectives of the situation under investigation.

Critical inquiry is founded in Marxist philosophy, and is conceived as a process that engages people and therefore can lead to political and social transformation. Crotty (1998) suggests that those who adopt a critical inquiry approach often have goals of equity and social justice and believe their research to be worthwhile. This approach fits naturally with the underlying political agenda of equity of care for all age groups in acute care sectors. Critical inquiry adopts an approach of scepticism to the idea that accepted ways of thinking are natural, rational and neutral. It also acknowledges the nature of power relationships in research and that power is not static but a dynamic and moving force.

These social goals, critical sceptical approach and stress on the importance of relationships, particularly those of power, are consistent with the focus of this research

as it addresses the experiences of care in a hierarchical organisation. They are also consistent with the origins of this research which were influenced by the increasingly high profile given to care of older people, by government and local health care deliverers (health boards) whose reports and research results did not correlate with the researcher's own experiences within the health care sector.

Adoption of a self-reflective stance by the researcher is key to critical inquiry (Alvesson and Skolberg 2000) as one must acknowledge the influences that will affect the analysis and interpretation of the data collected. The researcher, therefore, approaches the research by continually reflecting, adapting and acting on new ideas in a reflexive manner. The research process itself, therefore, offers an opportunity to learn about and change health care practice in the area of older people and acute care. Consequently, the outcomes and recommendations from this research have the potential to add to awareness and learning on a conceptual, practical and personal level.

## **Methodology**

The research questions focus on processes that are dynamic and therefore, require methodologies that are iterative, flexible and reflexive, and that can explore complexity rather than outcome. The nature of the older person's experience in acute care, the nurse's experiences and influences on the experience and the need to identify and understand the influences of the organisational context of the care experience do not allow for objective measurement. This is because they deal with the individual's experiences and how they interact and construct that experience. Therefore, a qualitative methodology is more appropriate in undertaking this research.

Qualitative research, as a method of naturalistic inquiry, aims to develop understanding of people, explore the phenomena and processes that influence them, investigate the processes through which people interact and increase the understanding of the meaning of social interaction by studying people in their natural social settings through collection of naturally occurring data. To do this methodologies are required that view events and the social world through the eyes of the people being studied and are interpreted from the perspectives of those people (Mays and Pope 1996, Bowling 2002). This form of inquiry takes its approach from the way in which theory and categorisation emerge out of the collection and analysis of data. A particular strength of qualitative methods is that one is free to change their focus as the data collection progresses. However, Silverman (1993) suggests that theory generation should not be the only use of qualitative methods as this may result in speculation, rather, at some stage the theory will also require testing. In qualitative research various methodological approaches exist which are selected on the basis of the purpose and outcomes of the study. For example, the purpose of the study may be to investigate and understand human experience, behaviour and interaction in a social context, as in this research. The methodological approach to this could be participant/non-participant observation and interviewing using grounded theory, phenomenology, ethnography or discourse/conversation analysis (Holloway and Jefferson 2000).

As this research explores questions that are dynamic, a methodology that is flexible, reflexive and iterative allows exploration of the complexities rather than quantifies the outcomes. This research therefore uses elements from ethno-methodology, which within

the sociological tradition allows the researcher to identify the way shared agreement is achieved within various social contexts. The purpose of ethno-methodology is to develop and clarify knowledge and understanding of everyday practices in society, by discovering how people make sense of everyday activities and interpret their social world. This particular method has the best fit with the researcher's aim to discover how older people make sense of their care in acute hospital settings, and what influences their understanding of that care. It also allows the researcher to gain an understanding of the social norms and assumptions that shape the behaviour of qualified nurses in different care contexts. There is no doubt that, had one wished only to examine older people's experiences of acute care; without reference to the interpretation they place on the care received and the setting it occurs in, a phenomenological method of inquiry would have been used. Phenomenology would have allowed the examination of the lived experience of care situation; however, as the idea was to find out how the participants constructed their care experiences and made sense of them, phenomenology was not appropriate. Similarly, if the only area of inquiry had been the work of qualified nurses, ecological psychology, using a case study might have been appropriate, as it offers the opportunity to examine behaviour as it is influenced by the environment.

Grounded theory, which has its foundations in symbolic interaction, would also offer an appropriate method for the research topic. Grounded theory has its basis in that meaning is socially constructed, negotiated and alters with time. However, true grounded theory approach does not start with focused research questions; rather the question emerges from the data. Thus its use in this case would be inappropriate as several questions



already exist based on the researcher's professional experiences and reading of the literature.

This does not preclude, however, the use of the grounded theory data analysis process of constant comparison to assist in refining the emerging hypothesis. Parahoo (1997) and Crookes and Davies (1999) suggest that grounded theory is not discipline bound and is really a set of processes and a form of analysis that guide researchers, rather than a distinct research method.

Therefore, for this research ethno-methodology is the research method of choice as it allows the understanding of how a person practically produces a sense of reality, where meanings are context specific and produced by each individual's interpretation about and in the setting (McCormack 2001).

The research questions focus on older people's experiences of acute care and nurses influences on the care environment. These questions require attention in relation to relationships and substantive contextual data which are more likely to be achieved through the use of more qualitative methods which fit with the epistemological, theoretical and methodological frameworks discussed previously.

This research used a combination of different methods to establish, collect and analyse the data. These included literature searches, semi-structured interviews, field notes, informal discussions and critical reflection. These methods combined adaptability and flexibility whilst enabling cross-checking between different methods and participants for consistency of information.

### **Literature searches**

Literature searches were carried out using a systematic approach and utilising several academic nursing and social science search engines. The Cumulative Index of Nursing and Allied Health Literature (CINAHL) was the main source of materials, although use was made of several others including Applied Social Science Index and Abstracts (ASSIA), British Nursing Index (BNI) and PubMed. Searches were carried out in the following areas: concept of care, nurses' work and older people, patient - nurse relationship, older people and experience of care, patients' perceptions of care, patient self-determination, context of care, nurses' perceptions of care giving, organisation and care.

These literature searches were conducted over a span of two years from 2001 to 2003. This approach was supplemented by the use of snowballing reference sources from within references, and through discussion with selected academic colleagues who were asked for suggestions of good literature in the research area. Literature searches occurred mainly during the first two years of the research and were then revisited after the data collection period to ensure currency and relevance and in order to update and expand the literature base.

### **Semi-structured interviews**

One to one semi-structured interviews were chosen as they are less formal than the fully structured interview. Semi-structured interviews allow for a question structure (see Appendix B and C) to be used, however, it is flexible and allows the direction of discussion to be adapted depending on the responses that occur during the interview.

This approach to interviewing also allows the introduction of subjects not anticipated or defined by the researcher. The interview schedules were developed using information identified as requiring further research from the literature review, along with elements that address the research aims.

The interviews, for both patients' and nurse sample groups, in this study were scheduled on the basis of one hour contact time, but with a flexibility that enabled this to range from 30 minutes to 120 minutes depending on the time availability of the participants and the requirement of the interview. No group interviews were held except on one occasion when a nurse respondent asked if a colleague could join the interview session as she too was interested in the study. The anonymity and confidentiality of the one to one interview was important particularly as the nurse interview schedule contained questions regarding management and organisational issues. This might have led to a respondent's answers being influenced by peer, or organisational pressures had they been asked in a group setting.

A specific interview reveals information about a particular person at a particular place and time, from one person's perspective (Pole and Lampard 2002), therefore, semi-structured interviews do not produce universally shared experiences.

The degree and structure of the interview schedules is also influenced greatly by the beliefs and theoretical disposition of the researcher. Even using a flexible interview design, there is a danger that the interviewee will answer in a manner that they think the interviewer wants, or that a view of reality is given that is so positive that it is unlikely to be completely representative. This could be a particular issue when interviewing the patient sample as they may feel constrained by their situation to be overly positive. In

order to overcome this issue, patient participant interviews will be undertaken post-discharge, as an attempt to prevent a halo effect occurring.

Thus, this interview approach hoped to capture the nature of knowledge, trends and opinions about older people and their experiences of acute care in one particular health care trust, but it will only ever produce a snapshot in time based on the realities of those individuals participating in the research.

### **Field notes**

Field notes were kept during the data collection period as a means of recording contextual and observational materials that did not fit within the framework of the formal interviews. Notes were recorded immediately following an interview that gave the researcher's feelings and views of the process and allowed the researcher to add information and experiences that would not be part of the formal transcript. Notes were also taken when informal discussions had occurred with nurses or patients following the end of the interview, or in chance discussions whilst in the hospital areas. The field notes were categorised by colour of pen to delineate issues relating to the researcher, post-interview comments, management issues and process issues. This colour coding allowed the researcher to categorise the field notes and later use them to illuminate the data analysis.

### **Informal discussions**

Informal discussions occurred between the researcher and members of the nursing profession, usually following a chance encounter in the data collection area. These

chance encounters allowed the researcher to test out ideas and themes that were emerging from the data with appropriate members of the nursing profession. These informal discussions also enabled the researcher to critically review the processes of the research and develop concepts and ideas that could feed into the data analysis.

### **Critical reflection**

Reflective practice is a key facet of critical enquiry and was an integral part of making sense of the data collected.

Field notes were written as soon as possible following an interview experience, in order that the information recorded was as reliable and objective as possible. Interviews were transcribed as soon as possible after the event to assist in the retention and recording of non-verbal information that may be important. The first 10 interviews were transcribed by the researcher but this became unmanageable over time and the remaining tapes (17) were transcribed by a professional audio-typist employed for that purpose. The process of transcription enabled a reliving of the data collection experience and was an important time for reflection, and thus those tapes that were not personally transcribed were re-listened to whilst reading the transcripts in order to allow reflection. During this process notes were made of ideas and themes that were emerging from the interviews. Reflection was also taking place during research supervision meetings, where perceptions and ideas were challenged and debated, notes were also kept of these meetings. The following section outlines the settings in which these data collection methods were undertaken.

## **Data collection settings**

The local NHS Trust was selected as the data collection setting, for pragmatic reasons. The researcher had previously worked for the Trust and had knowledge of the areas available for sample recruitment. Similarly, as the researcher was undertaking this research whilst working in a full-time job, easy accessibility was crucial to the time management of the research. Within the local NHS Trust there are two major teaching hospitals and one hospital specifically orientated to care of older people. This would allow the researcher to access the required sample groups. However, at the time that data collection commenced, one of the teaching hospitals was going through a period of major change and it was decided that this would not be used as a data collection site due to the influences that the effect of the changes might have on the nurse's and patient's expectations and experiences.

The data collection settings were split into two areas: acute medical care of older people (AMC), and acute care (AC).

Acute medical care of older people settings consist of wards where the focus and attention of the care delivery is specific to the specialism of medical care of the elderly. Thus in these settings the medical staff have specialised expertise in the complex and multi-pathological health issues affecting older people. The ward populations are aged 65 and over, and the tendency is for the patient to stay in the ward for two weeks or longer whilst they undergo investigations and treatment of various medical conditions. Discharge from these wards is either to the patients own home or to long stay facilities in the community. Nurses who staff these wards do not tend to have any specialist training or education in care of older people.

Acute care wards are areas that focus on admitting patients with specific pathologies or care needs regardless of age; for example gastro-intestinal or respiratory, and either offer medical or surgical treatment of the condition. Patients in these wards have an age range of 16 years plus, and in surgical wards the length of stay is on average 5 days. In medical wards depending on the specialty the length of stay can range between 5 days and a month. In acute care wards the discharge assumption is that the patient will return to their own home from the ward. Nurses in these settings are more likely to have been offered and undergone further training and education in the specialist area.

In the event, the nature of the acute care setting became much more specific than had been anticipated, becoming focussed in the Department of Clinical Neurosciences which contains both medical and surgical areas. This was due to a lack of positive response requesting access to the areas, from the clinical nurse managers in other acute areas in the hospital, although initial letters and e-mails had been followed up twice.

### **Ethical approval and negotiating access.**

The process of gaining ethical approval was commenced concurrently with negotiation of access to the research site, as agreement from the NHS Trust was required as part of the ethical approval process. The start of negotiation coincided with the implementation, within the local Heath Trust, of the research governance process and this caused several delays within the process. An initial letter to the Director of the Research and Development office (RDO) in the NHS Trust requesting access was sent in late November 2003 (Appendix D). No response was received to this letter and a second letter was sent in January 2004 (Appendix E) to which a response was received

by return, indicating that the Acute division of the Trust was an appropriate place to undertake the research and that they would process the request through their systems.

The Senior Nurse – Research (SN) was nominated by the RDO as the main contact person for negotiating access to the sample. A meeting was arranged with the Senior Nurse to discuss the proposed research and the appropriate ways of negotiating access. It was agreed at that meeting that, following contact between the senior nurse and relevant nurse managers in the Trust, letters would be sent by the researcher to the Principal Nurses/Assistant General Managers explaining the research and requesting their support and also their views on the appropriate people to contact for access (Appendix F). The SN was concerned that as interviews would take place in the patient's home the Primary Care Trust (PCT) should also provide ethical approval, and the researcher undertook to establish the need for this. A response was received from the Community Nursing Research Facilitator of the PCT indicating that management approval was not required from the PCT for this piece of research (Appendix G).

It was also indicated at that time, by the SN, that the researcher would require an Occupational Health check and a Scottish Criminal Records Office (SCRO) check to allow the awarding of an honorary contract with the Trust. This would validate the researcher as a bona fide member of the Trust for data collection purposes. These two processes were undertaken and the results forwarded to the Human Resources Department of the Trust. Following several e-mails between the researcher and Senior Nurse, no honorary contract materialised and the SN finally suggested the data collection go ahead without this document, and the researcher used the staff identification card from the University as a means of identification.



Whilst the access was being negotiated, ethical approval was being sought through the Lothian Research Ethics Committee (LREC). The date of the next meeting of the appropriate sub-group of LREC was established by consulting the LREC website and the documentation prepared in good time for submission to the committee. Twenty copies of the completed LREC (2002) Application form along with supporting documents were submitted with a covering letter. A letter confirming receipt of the documents and indicating the date of the meeting was received, along with an invitation to attend to answer any questions that should arise (Appendix H). Having attended the LREC meeting on March 3<sup>rd</sup> 2004 but not been required for additional questioning, a further letter was received indicating granting of a favourable ethical opinion subject to changes to some of the details on the forms and following convenor's action. These changes were made and resubmitted in April 2004 (Appendix I) with final approval being granted and a Certificate of Ethical Approval awarded (Appendix J).

Following receipt of ethical approval, letters were written to the Director of Nursing and the Principal Nurses of the NHS Trust to establish contact and gain access to the acute care areas. Positive replies were received from all recipients and the researcher took steps to establish contact with the nurses indicated in the letters. This contact was made by e-mail as the SN indicated that a response was more likely through that approach than a formal letter. One Assistant Directorate Manager (ADM) (acute medical care of older people) requested a meeting, one other (acute care wards) suggested attending the next Charge Nurse meeting being held in the Division and two other acute care division

managers did not respond, even after follow-up e-mails and phone calls. Cresswell (1998) indicates that gaining access to the research site through 'gatekeepers' is very important as these people can hinder or assist the research process and advises a slow approach for gaining access. The nurse managers at varying levels are the gatekeepers in this instance and the time taken to gain access ended up being five months. On receiving management approval the researcher commenced recruiting the sample.

### **Recruiting the sample**

This study endeavours to discover how older people make sense of their care in acute health care settings, and to establish what influences their understanding of that care. It also seeks to gain knowledge of the nurse's underpinning beliefs about care and the influence of the organisation on the nurse's ability to act on those beliefs. As the researcher is seeking to discover meanings, and uncover differing interpretations of the reality of care, a sample that allows the best opportunity to collect the required data was selected (Parahoo 1997). This selection of a purposive sample is, Cresswell (1998) suggests, a key decision point in a qualitative study as the researcher should have clear criteria in mind and provide reasons for their decisions. The specific strategy used for this research was a combination of criterion sampling where all the individuals studied had experience of the situation being researched, and opportunistic sampling which takes advantage of the unexpected whereby informal meetings with nurses in hospital corridors led to recruitment to the sample (Miles and Huberman 1994)

To establish whether the context of care affected patients' experiences, and also whether nurses working in specific areas held different beliefs about care, two separate care

contexts were finally used as sample sites. These were the acute medical care of the elderly wards, of which there were seven in the data collection area; and one acute care division which consisted of three wards. In qualitative research there are no established criteria for sample size and Polit et al. (2001) suggest that sample size is determined on the basis of data saturation, where no new information is being gained and redundancy is achieved. The sample size for this research was anticipated at being 20 patients and 20 nurses, which took into account that data gathering and analysis in qualitative research is time consuming and requires a large amount of time and effort in its translation. In the event, the final sample consisted of 13 patients and 14 nurses which took into account participant withdrawals following recruitment, and also reflected the political situation in relation to the implementation of a new pay and conditions structure in the organisation at the time of data collection and recruitment. Nurses were being expected to justify their position on the new pay scales and this was the total focus of their attention.

### **Recruitment of nurses**

The nursing staff sample was selected purposively and opportunistically using the following inclusion and exclusion criteria. Nurses were all qualified nurses of D,E, F or G grade who were in permanent employment in the selected wards. Nurses who were Agency or bank nurses were excluded as it was felt that they might not be an integral part of the organisational context of care for that ward and therefore would not be working within the same contextual frame as permanent staff. Similarly, non-qualified personnel, although actively involved in patient care as part of the ward team, do not

carry the same responsibility in meeting organisational demands and will not have been exposed, by nature of the educational process, to the professional values system of registered nurses.

The researcher attended a Charge Nurse meeting for the acute care division, as had been suggested by the Assistant Directorate Manager (ADM).

This gave the opportunity to explain the research, discuss any issues, offer Charge Nurses the chance to volunteer as part of the sample, and establish their views on recruiting the nurse sample. Following discussions with the Charge Nurses the following approach was developed and used.

A laminated A4 poster inviting qualified nurses to volunteer to be part of the study was attached to the notice-boards at the nurses' stations in all the acute care wards. Envelope packages containing letters, information sheets, consent forms and postage paid reply envelopes were placed below the poster for staff to take, read and finally make decisions on participation.

In the acute medical care of the elderly wards a meeting was arranged with the Assistant Directorate Manager (ADM), who was anxious to establish that the researcher was not looking for data relating to poor care situations. Once she was convinced of the nature of the study, she agreed that following the monthly charge nurse meeting; where she would explain what the researcher was doing, the researcher could have access to the acute medical care of older people wards which were located in the teaching hospital and the specific care of older people hospital. The researcher had proposed holding open meetings on two or three occasions to allow staff to hear about the project but this was

rejected by the ADM on the grounds that the staff did not have time to attend these things.

Once the Charge Nurse meeting had been held, the researcher visited all the wards; using the same approach of posters and information sheets. This allowed the researcher to speak to the nurse in charge during her visit and explain what was being undertaken. It also allowed the researcher to encourage any qualified staff to read the poster and information leaflets and then consider volunteering.

These recruiting approaches generated an initial 5 volunteers. Data collection commenced and as the researcher was seen more often in the ward environment, further volunteers were recruited, with a final sample of 14 being recruited. However, the researcher spent a lot of time during the ward visits encouraging staff to volunteer as they were particularly reluctant to participate. This reluctance may have been due to peer pressure, pressures of work or the organisational climate of change as a new hierarchy and pay structure was due to be introduced in the next few months.

The researcher was known to some of the staff, who had previously been students at Queen Margaret University (College) and this was useful as it allowed them to speak with their colleagues and increased the researcher's credibility in the eyes of the nursing staff. A confounding factor in the recruitment of nursing staff was the introduction, towards the end of the recruitment period, of the National Health Service 'Agenda for Change' pay scales review. Volunteering for the sample ceased completely, and no amount of encouragement changed this. The researcher can fully understand why this occurred, as being a research sample is, in any event, not high in the nurse's priorities but this new pay scale completely took over the nurse population's thinking and they

expressed the view to the researcher, that there was no point in participating as nothing would change their situation.

Following receipt of the consent forms the researcher contacted the nurses and arranged interview appointments. These were conducted at a place and time to suit the sample, with the majority being undertaken during the nurse's working hours in the hospital environment. Some nurses requested interviews be held at the University or their own homes and this was arranged. A breakdown of characteristics of the nurse sample is given in Table 3.1.

**Table 3.1      Characteristics of Nurse sample**

Setting	Number of Female staff	Number of Male staff	Number of staff
Acute medical care of the Elderly	8	0	8
Acute care (medical and surgical wards)	5	1	6

### **Recruitment of patients**

The patient sample was a purposive convenience sample. Inclusion criteria were that the patient must be a UK resident and aged 65 or over. The choice of 65 as the age criteria was based purely on the current retirement age definition. Excluded from the sample were patients:

- who were unable to give informed consent through mental incapacity. This exclusion was used as older people with mental incapacity potentially will interpret their care experiences in a different way from the general population of older people. They would not be able to give informed consent and as a

vulnerable group would be less accessible once they were discharged from the acute settings of care.

- whose first language was not English. This exclusion prevented the need for an interpreter, and also the nature of the research was to understand how older people constructed the reality of their care experiences. This group are excluded because they are unlikely to have the same social and cultural backgrounds/expectations as those who have lived within an English speaking culture. This in itself would not preclude study into their experiences but as there has been no research into this area so far the researcher felt it would be beneficial to gain an understanding from those who were well settled in the social context of NHS care first. Inclusion of this group could introduce a confounding element to the study.
- who were below the age of 65, due to using the standard definition of older person
- who were non-UK residents. These people were excluded for social context reasons as identified above.

The researcher visited all data collection wards on a regular basis at least once a week. This visit was made to establish from the nurses those patients who were due for discharge and, therefore, could be approached regarding the research. The acute care wards were visited twice a week as the patients had shorter stays and were discharged more regularly. At each visit the nurse in charge informed the researcher of patients, who met the criteria in terms of age, ethnicity and cognitive functioning, who were due

to be discharged in the next 2-3 days. The researcher then approached these patients in the ward and explained the nature of the research. An information letter and consent form was left with the patient and they were offered 48 hours to consider their response to the request for volunteers. The patients were encouraged to discuss the research with their relatives and appropriate others. After 48 hours the researcher returned to the ward, answered any questions and collected any consent forms. On several occasions at the return visit the patient had been discharged but had left the consent and information forms for collection by the researcher. At this point the patient's contact address and telephone number were noted by the researcher and she reiterated to the patient that she would telephone, following the patient's discharge, to arrange a visit to the patient's home to conduct the interview. This visit would be arranged for 3 – 6 weeks after the patient had been discharged. Each patient was given a card stating that the researcher would contact them in 3-6 weeks, and giving contact details should they decide to withdraw from the study.

This approach recruited a sample of 16 patients, three of whom subsequently withdrew from the study when contacted to arrange an interview appointment.

See Table 3.2 for characteristics of patient interviewees.

**Table 3.2 Characteristics of patient interviewees**

Setting	Female participants	Age	Length of stay	Male participants	Age	Length of stay	Total No. of participants
AMC of the Elderly	2	65 – 74	<14day	1	75+	<14day	8
	2	65 – 74	>14day				
	3	75+	>14day				
AC medical	2	65 – 74	<14day	1	65 – 74	>14day	3
AC surgical				1	65 – 74	<14day	2
				1	75+	<14day	



### **Ethical considerations**

The principle of research ethics is that participants should not be harmed in any way as a result of participating in the research and that participants give informed consent to participate (Bowling 2002). This research was granted ethical approval by Lothian Research and Ethics committee in May 2004. The need for confidentiality and anonymity are important considerations when undertaking research with people, as they need to be assured that their right to privacy has been safeguarded (Parahoo 1997). All semi-structured interviews were tape-recorded and transcribed once written consent had been gained. The right to privacy was safeguarded by all participants being given a numeric identifier known only to the researcher. All tape-recordings and transcripts were kept secure in a locked cabinet within a lockable room.

The interview process has, according to Parahoo (1997) the possibility to be harmful, thus interviewees were given the opportunity to withdraw from the study at anytime and with no explanation being required. No nurses withdrew, however, two patients withdrew following initial consent, and one patient withdrew as they became re-hospitalised before the interview took place. Financial inducements were not offered to any participants or persons connected with this research at any time as this could be seen as coercing participation.

### **Data Collection**

Data collection took place in the period between July 2005 and May 2006. The majority of patient interviews were undertaken between July and September 2005, reflecting the time available to the researcher for this activity due to the academic vacation. Nurse

interviews were undertaken from June 2005 and completed in May 2006, this again reflects the difficulty in recruiting participants and finalising interview times. All data collection took place in locations around Edinburgh and the central belt of Scotland, and ranged from patients and nurses' homes to ward staff rooms.

The main form of data collection consisted of semi-structured interviews, with field notes being written up, either during observation of activities on the wards whilst awaiting nurse appointments or access to patients, or following interviews when further information was offered that could be pertinent to the study.

Initially interviews were transcribed by the researcher and this allowed the opportunity for reflection on the data and led to the emergence of initial ideas and potential themes that informed questions in the later interviews. Reflection also informed the later literature searches and the informal discussions with nurses along with the repeated exploration of transcripts for these and other new themes and categories.

### **Data analysis**

Creswell (1998) suggests that analysing multiple forms of data is a redoubtable task for qualitative researchers, with Miles and Huberman (1994) suggesting that early data analysis is important as it prevents data analysis becoming a giant that overwhelms the researcher and allows for generation of new data to fill gaps. Although the researcher used the process of transcription of interviews as a means of identifying potential themes and ideas, the primary data analysis did not occur until all interviews had been transcribed. This was to some extent dictated by the nature of studying for a PhD part-time where time constraints affect the approaches used in the research. Coding was the

starting point for the analysis of data; it is the process of turning qualitative replies to open-ended questions into some sort of approximation of quantity that allows patterns and themes in the data to be identified and analysed (Miles and Huberman 1994, Seale 2000).

An inductive coding approach was used reflecting the original “grounded” approach advocated by Glaser and Strauss (1967). Pre-coding of data is not undertaken allowing the researcher to see how it functions in its context. Codes are used to retrieve and organise chunks of material that have specific meanings in a specific context. By identifying codes that relate to chunks of information text can be categorised and further analysed (Strauss and Corbin 1990). For example, in this research categories were generated through data review with a category Nurses approaches to Care Work – NRCW being generate. This was then refined through further data reading to 10 sub-categories, one of which being NRCW- PV (personal views). The full coding lists for nurses and patients can be seen in Appendix K and an example of coded pages in Appendix L.

In order to improve credibility of the codings, two colleagues were asked to independently read and code a patient transcript and a nurse transcript. Following these independent codings, discussion with the colleagues allowed the researcher to be assured that the codes ascribed were appropriate to the transcript analysis.

Although computer programs exist to assist in the analysis of qualitative data, in particular for this research, the programs Ethnography and N6 (formerly known as N\*Dist), the decision was made, based on time and IT experience, to undertake this process manually. Although Creswell (1998) identifies several advantages to

computerised programs particularly for understanding large text databases, it was decided to undertake the coding for this study by hand. There would have been a need to learn how to use the program which Creswell (1998) suggests is beyond learning what is required for understanding the procedures of qualitative research. At the time of the research it was felt that to gain an understanding of, and learn to use a computer program would take time that could ill be afforded for this activity. Similarly Creswell (1998) identifies other disadvantages to computerised programs, suggesting that the program can be substituted for careful analysis of the materials and individuals may be reluctant to alter or change categories because of the use of the program.

As the coding progressed, further analysis was needed to draw out more detail of the themes emerging. Cross checking of the interview transcripts and field notes was necessary to establish clear findings. This process suggests that the multi-layered analysis necessary for good quality, reliable qualitative data is more time-consuming and on-going than is often implied in research texts (Alvesson and Skolberg 2000) and analysis was undertaken through development of concept maps which allowed for the complexities of the analysis to be detailed and revisited on a regular basis. Concept mapping allowed for the links and cross-links to be identified between different concept areas that emerged from the data, thus assisting in making sense of the data (Jackson and Trochim 2002). An example of the concept maps is given in Appendix M.

## **Dissemination**

The end stage of the research is often seen as the most important point of dissemination of the research findings. However, there may be other dissemination opportunities

through out the research period. Work in progress in the form of a literature review was presented at a European conference in March 2004.<sup>1</sup> This paper provided opportunities for interested parties to learn more about the initial stages of this research and for constructive feedback and debate to be incorporated into the research where appropriate. The main research findings from this study will be produced as a summary report that will be available to all participants and others interested in this work. It is also intended that several journal articles will be written to disseminate the findings following the completion of this thesis.

The research findings in this thesis represent a snapshot of a particular area of study at one moment in time. The process of reflection is iterative and should potentially continue ceaselessly, thus it would be expected that any journal articles resulting from this work will contain further reflection beyond the end of completion of the thesis.

### **The influence of the researcher**

Recognition of the influence of the researcher on the research is acknowledged through the use of social constructionism as an epistemology. Allan (2004) also notes that attention to the issues of identity, social status and the role of the researcher in the generation of data is important in the practice of ethnography. The need for transparency of reflexivity in this study is relevant in order to augment the rigour of the research and allow the researcher and reader to assess the validity of the findings (Atkinson and Coffrey 2002). Within the interpretive inquiry tradition it is claimed that the participants

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<sup>1</sup> A paper based on the first conceptualisation of ideas from the literature was presented at the 5<sup>th</sup> European Regional Conference of the Commonwealth Nurses Federation in Malta in March 2004.

and researcher can mutually influence and learn from one another and, therefore, the peculiar characteristics and identities of the researcher and participants impact directly on the research outcomes (Bowling 2002, Creswell 1998, Silverman 1998).

The researcher's background in health and nursing, with a particular interest in older people and aspects of their care, influenced the direction of this research. The characteristics of being a lecturer in a higher education institution, but also having previously had a career in nursing older people influenced this research in a number of ways.

The researcher was an 'outsider' to the staff and patients in the hospital settings; however, this role had advantages and disadvantages.

In the wards, the status of being a lecturer in a highly regarded higher education institution, gave unchallenged access to areas of the wards that might otherwise have required negotiation through the ward managers. The nurses accepted my presence on the wards without question at any time and patients were interested to be part of a research study that appeared to them to carry worth and status – this was indicated through comments made whilst recruiting. Whilst this certainly made the progress of the research smoother in terms of access and recruitment of patients, it caused the researcher some anxieties and discomfort. There were feelings of being fraudulent, and not 'valid' in the role being ascribed to me as researcher. (Field notes 1.2) *'still anxious about approaching staff regarding patient access, and also patients themselves – keep putting it off. Wonder if it's because I don't feel 'valid' in that role – maybe an NHS name badge would help – speak to SN about Honorary contract etc.'*

The researcher's previous status as a qualified nurse in care of older people settings certainly appeared to influence the information that was divulged to me. The nursing staff were comfortable using language that reflected our common nursing background, particularly when they were identifying and suggesting patients for the researcher to approach. Nurse participants, in the medical care of older people settings, also seemed to want to develop an allegiance with the researcher through recognition of our common nursing background. This was done through the use of phrases such as *'you'll understand this because you have been a nurse here'* (N1AMC).

To some extent this was also a disadvantage as often the nurses would make decisions, regarding telling about a patient, based on their own assumptions about the nature of the research. On a number of occasions nurse participants saw the research as a means of getting information and issues to their managers.

Patient participants were quick to assure the researcher that everything was fine in term of their care, as they seemed to think the researcher was looking for negative experiences of care. This might reflect the impact of the high level of media coverage that had highlighted poor episodes of patient care in the recent past.

In all cases where misunderstanding arose the researcher gave more information to clarify the nature and reasons for the research. This clarification seemed to make little or no difference to how the researcher was treated, or to the flow of the interviews.

Although the researcher's personal background cannot be altered, the choices made at all levels in the research process had an impact on the study. The choice of research topic had the greatest influence but also the researcher's role in interpreting and reflecting on the research process has led the study in particular directions.

For example, the use of elements of ethno-methodology and reflective methods throughout the research led to a more concentrated focus and analysis of the notion of relationships and the cultural context of care.

All parts of the research process are open to researcher influence, from data collection through to carefully written accounts and there was a potential disadvantage of the possibility of making assumptions because the researcher was a nurse. Maggs-Rapport (2000) suggests that through a multidimensional approach to research the researcher may come closer to understanding their personal interpretations of the research and the experiences of the participants. Even the most consistent academic writing is open to individual interpretation, with Crotty (1998) suggesting that there can be a difference between the intention of the author and the experience of the reader.

## **Summary**

The research methodology was underpinned by the philosophical approach of social constructionism, and used a theoretical framework of critical inquiry. In order to achieve a flexible, iterative and reflexive methodology, elements of ethno-methodology were used discover how older people make sense of their experiences in acute care and interpret their social world in hospital.

Methods used within the research were literature searching over several periods of time using several academic nursing and social science databases; semi-structured interviews; field notes; informal discussions and critical reflection. Data collection occurred following the gaining of ethical approval and negotiating access, with recruitment of nurses and patients from acute care settings in a local NHS Trust. Data analysis was



undertaken manually rather than using computer aided analysis, with an inductive coding approach used to generate categories for analysis. Multi-layered analysis using concept mapping allowed for the complexities of the analysis to be detailed, with links and cross-links identified between different concept areas emerging from the data, and these maps were revisited on a regular basis. Influence of the researcher on the research was recognised and acknowledged through the use of social constructionism, with attention paid to the need for transparency of reflexivity as a means of engendering rigour in the research.

The intention of the research is to gain an understanding of the older person's experiences of acute care and how they make sense of that experience therefore, the following six chapters analyse the data results and explore the research findings in relation to the patient's experiences of care. The first three chapters address patient's responses to the care situation, their interactions with nurses and their person-orientated experience of care. These are followed by chapters on the nurses' explanations of care work, nurse's relationships in the care setting and nurses and the organisational context of care. Finally a seventh discussion chapter draws together the main elements of the research.

## **CHAPTER 5**

### **PATIENTS' RESPONSES TO THE SITUATION**

This research aimed to examine the experiences of older people within acute health care settings, and to locate older people's experiences in the context of two organisational care settings. These settings being acute care wards and acute medical care of older people wards. The objectives were to establish how older people define themselves within the context of hospitalisation and society and to analyse the nature of older people's interactions with nurses.

This chapter discusses the key features of patients' responses to the cultural context of the care environment. Within this, several coded categories emerge: uncritical acceptance, justification of care, role acceptance and criticism of care culture. These will be considered in relation to both care settings as no apparent differences emerged from the findings between the two data collection settings for these categories.

#### **Uncritical acceptance**

Reflecting the work of Coyle and Williams (2001) and Macduff (1998) almost without exception all the participants prefaced and interspersed their interview sessions with blanket evaluative statements that were positive, generalised and non-critical of their hospital stay and affirmed the care they received as good.

*Pt3AMC<sup>2</sup> “it couldn’t have been nicer”*

*Pt14 AMC “Aye, they were awfy good”*

*Pt6 AC “I just think the staff in the ..... are absolutely fabulous”*

*Pt2 AMC “I thought they were all very helpful and very kind”*

*Pt8 AC “oh aye...I mean the care was all right”*

*Pt1AC “I’ve got nothing but admiration for them all, actually I don’t think there’s anything at all of a complaint.”*

This unconditional acceptance of the care they received was contradicted by the interview data where the respondents identified both positive and negative experiences during their hospital stay. This unquestioning acceptance of the care received could stem from several reasons. Firstly, due to the age of the sample group, many could remember a time when the NHS did not exist and were to some extent grateful for any care. In relation to the NHS, Pt2AMC commented *“it was not like in our day when we were young, we worked jolly hard to pay for healthcare”*. Similarly, the nature and upbringing of the participants could affect their expectations, with this particular age group being more likely to accept what they are told, and also that they will be told what to do.

*Pt5AMC “You expected to be more or less told what you should do and what not”*

*Pt9AMC “I would never have dreamt of saying what we wanted, we accepted what....we didn’t have expectations like that.....but I think even if I hadn’t had a nice experience with everyone being so friendly and understanding that I would probably have felt*

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<sup>2</sup> All ward identifiers have been replaced with either AMC – Acute Medical Care of older people, or AC – Acute Care to protect anonymity, but reflect the ethos of the care setting.

*inhibited about complaining. You know, now is that because we were brought up...when I was young that you didn't complain you accepted things as they were?*

New knowledge emerged when this aspect was explored further with participants, using questions relating to what the respondent had expected in terms of care. Several compared their own experiences favourably against headline cases of poor care that had been reported in the media, and therefore felt they had had a reasonable time. One respondent identified that she had not expected so many auxiliaries to be undertaking the work, and that auxiliaries were also being trained in technical skills such as taking patients' temperatures and blood pressures, whereas she had assumed, from previous experience 10 years ago, that qualified nurses would be doing this work.

The unconditional acceptance, therefore, could be a means of the participants protecting themselves from a negative experience by rationalising their stay as a 'good' one in comparison to the media generated criticism of the NHS, or as they have gained the desired outcome of being out of hospital they may be redefining their experiences as 'good' to cope with what might have been quite a traumatic and unpleasant experience. Participants also explained about other patients' behaviour, that they felt was wrong, in terms of the person having been influenced by the media to expect 'poor' care and thus the patient behaved in an aggressive and challenging manner from their admission.

*Pt6AC “ and when you open the paper there's things about hospitals being dirty and the staff not bothering and things happening that shouldn't happen in hospitals and I think a lot of people when they go into hospitals are thinking that at the back of their minds, and*

*they treat the staff, I think, accordingly...they expect it to be bad. I've heard them quite nasty talking to the nurses...on one occasion the nurse was...she just had to walk away because I think the patient would have hit her."*

*Pt2AMC "I think some people are convinced that there is nothing right about hospitals. You hear them going on...no, I'm not doing this and I'm not doing that...."*

What might have been perceived as 'bad' behaviour in patients, such as shouting, was also elucidated by participants in terms of the people being in hospital and possibly on medication, or had illnesses or treatments that changed or affected the behaviour.

Two participants, Pt1AC and Pt8AC, had never previously been in hospital, both expressed views that the reality was not what they had expected. Interestingly when further questioned on this aspect, neither of them could articulate what it was they had expected, although there were assumptions made by the participants about certain things. For example, Pt1AC was admitted through Accident and Emergency (A and E) and had no real recollection of the time spent there. However, he suggested he must have waited a good long time because it was A and E, thus suggesting that the media reporting of waiting times in A and E had, had an impact on his expectations.

These two participants' views mainly related to the physical environment in terms of numbers of people, activity, noise and light.

*Pt1AC "It was a lot busier than I expected....there was continual movement, I was surprised by how much attention was being given to people.*

*Pt8AC “I was expecting it to be sort of dormant and quiet and you would get to sleep... and you got the nurses coming in at 6 o’clock to give you your tablets and that”... “ it was just the noise....then of course when they put the lights on they....didn’t close the door... so you could hear the racket all the time.”*

Pt8AC’s idea of a calm and quiet environment could be influenced by previous exposure to information regarding nursing where wards may have been portrayed as tidy, regimented areas with patients all lying in bed quietly circa 1950’s.

Two other participants in particular were extremely accepting of the care they received with almost no identification of negative experiences during their hospital stay, and those that were identified related mainly to the physical environment and lack of information. This is possibly due to these particular participants being highly accepting of the role of patient as they had been in that ward on a regular basis due to their condition. Further discussion relating to this aspect of unconditional acceptance will occur in the later section on role acceptance.

Why this uncritical acceptance occurred could also be explained by the participants’ abilities to justify the care they received.

### **Justification of Care**

The justification of care emerged mainly from the participants’ desire to explain, and to some extent absolve, nurses’ from any blame regarding their negative experiences of care. Similarly to Koch et al.’s (1995) work, where patients identified routine geriatric care as part of their experience, the notion of routinised care emerged as a justification for the participants’ care experiences.

*Pt8AC "I don't know it is just maybe...it is maybe routine."*

*Pt9AMC "oh that was all pre-planned and I would think it would have to be in that ward. It was an early start and breakfast was at a certain time...well I expected that because they have got to work to a strict timetable I imagine. Everything planned."*

Much of this justification was framed around nurses having to do certain routinised things to meet organisational demands— particularly registered nurses, who were busy doing paperwork but other areas identified revolved around physical care tasks such as drug rounds and technical care, as identified by Webb and Hope (1995). However, negative experiences of care mirrored those found by Koch et al. (1995) which included lack of information, non-facilitative care, no decision making opportunities, non patient centred care and lack of choice. Given that Koch et al.'s (1995) work was in an acute care of older people setting, it is unsurprising that similar results were obtained from this care setting in this research. However, the negative care experiences of participants in the acute ward settings reflected these same aspects, which suggest that the negative care experiences occur in any setting and is, therefore, not situation dependent.

These negative experiences were all explained away by the participants using the argument that the nurses had to use routinised care because they were short staffed and the nurses were busy. This reflects Coyle and Williams's (2001) results where 44% of the sample agreed they did not like to 'bother' nurses because they seemed so busy.

*Pt5AMC "they were...I think short staffed."*

*Pt9AMC "but I did feel that the poor nurses were rushed off their feet....and I just felt that what was needed there was more nurses, you know."*

*Pt2AMC “I did and...I go.....absolutely...because they were busy.” “ I think they don’t have enough staff at all”*

*Pt6AC “and the amount of nurses that were on the ward there wasn’t enough of them. So it wasn’t their fault it was the system if you know what I mean.” “I think (names charge nurse) tried to take a lot of the paperwork off the girls (means other nurses) but they still had to do an awful lot of paperwork.*

Participants gained this knowledge about staffing and nurses being busy through several separate means.

Firstly, through direct experience and observation of nurse behaviour, participants made assumptions that nurses were busy. Some of the evidence for their assumptions came from having to wait a long time for a call bell to be answered, or from a nurse saying they would return in two minutes and then not returning, or returning much later. One respondent identified what she called ‘nurses’ minutes’ as a means of explaining this:

*Pt5AMC “ yes because I said to them at one point, I know there is 60 seconds in a minute but how long is a nurse’s minute. And they said oh half an hour”.*

*Pt10AC “they (the nurses) say they will come back in a minute but then they don’t and you wait a long time”*

This use of extended time periods by nurses before returning, appeared to be accepted by participants as a norm, and they did not query or challenge it although it often meant they were waiting for long periods of time for assistance. Again, this was seen as an indication of the nurses being busy rather than forgetting or ignoring the patient’s requests and reflects results from several authors researching nurses views on issues that



affect delivery of quality care (Allan 2002, Idvall and Rooke 1998, Redfern and Norman 1999b, Skott and Eriksonn 2005, Wilkin and Slevin 2004, Williams 1998)

Secondly, participants who were in shared rooms observed staff interaction with other patients, and compared their own need for care with other patients, usually in the terms that the others seemed to require more extensive nursing care. For example, Pt9AMC compared herself and her need for care with another patient who needed much more nurse assistance in terms of care and attention requiring at least 2 nurses each time.

*Pt9AMC “ I did feel that the poor nurses they were rushed off their feet, and looking after the other 3 in my ward...one was in bed all the time and needed a lot of attention and a single nurse never seemed sufficient on their own, it would need 2 or 3.*

Similarly, Pt1AC indicated there was a patient who required a great deal of nursing care and in comparison described himself as not being ill, just incapacitated. This particular respondent couldn't move at all having fallen and bruised his spine, and therefore required help with personal hygiene and mobility but in his eyes he was not ill.

*Pt1AC “I felt rather guilty about the whole thing all the way along, occupying an acute bed, when in a sense there wasn't that much wrong with me.”*

Several participants reflected this view of not being ill enough or deserving of nursing care;

*Pt9AMC “ no, no especially because there were four of us in that ward and I obviously was physically more able than the others so I really didn’t need a lot of attention but the others did.”*

*Pt8AC (who had a brain tumour removed) “ I don’t think it was that bad. I think if it had been a serious operation they would help more”*

and to some extent a mentality of being fraudulent in occupying a bed because they should just get on with life.

*Pt10AC “ the people in the bay just helped each other and we just got on with it, very much do it yourself, but then we were brought up to just get on with things”*

*Pt9AMC “You know, now that is because we were brought up...when I was young you didn’t complain you, you accepted things as they were.”*

The notion of being a patient and therefore having rights and expectations for care was not apparent in the data.

Finally, participants drew conclusions regarding staffing and nurses being busy from direct discussion with the nurses themselves; the nurses seemed to tell or indicate to patients how busy they were. Nurses indicated to patients that the demands of the organisation in terms of expected paperwork, along with the notion that they were short-staffed, were the cause of their tardiness in responding to a call bell, or returning to a patient following a request.

*Pt2AMC “I said are you awfully busy, and he (the nurse) said yes we are there are two staff not coming in”*

*Pt6AC “they had an awful lot of paperwork to do.....(names nurse) used to tell me she tried to take a lot of the paperwork off the other nurses, but they still had a awful lot”*

Many of the participants accepted these explanations at face value and were highly tolerant of having to wait, sometimes for extended periods of time, for assistance. These issues of paperwork and time will be readdressed in the analysis of the nursing responses in Chapter 9.

An explanation of the patient tolerance of negative experiences may be found through exploration of the coded category Role Acceptance discussed below.

### **Role Acceptance.**

Coyle and Williams (2001), Irurita (1996) and Irurita and Williams (2001) all suggest that patients require to preserve integrity to achieve positive outcomes in their care experiences. Confirming the data of Irurita (1996) and Irurita and Williams (2001), participants saw themselves as having a role in the process of achieving good care through their behaviour. This role involved, as one respondent described it, ‘playing the game’. In other words the participants perceived that in order to have an acceptable stay in hospital they needed to behave in certain ways, although they did not articulate specifically where the perception arose from.

*Pt6AC “I just found that if you didn’t moan you got a better reaction with the nurses.....if you were a reasonable type of person the nurses got on great with you.*

*Pt2AMC “actually I don’t buzz unless I have to because they were busy.”*

However, the participants’ response to those patients who did not, to their minds behave appropriately gives some clues to how they saw appropriate behaviour.

Indeed, participants commented unfavourably about fellow patients’ who did not, in their eyes behave in an appropriate manner. This included the excessive use of call bells for no apparent reason and making what were perceived as unnecessary requests. However, conversely some participants did not use the call bell to get assistance as they perceived that nurses did not respond to it.

In this situation the nurses are perhaps, unwittingly reinforcing behaviour in patients; through behavioural conditioning, that is seen as ‘playing the game’ by not responding to these calls. Other participants only called when necessary and were resigned to a long wait for a response, or became anxious and worried, thus making it a negative experience.

*Pt2AMC “Well I finished (on the toilet) and I pressed the button, and nothing happened. I thought what’s going to happen next, so I managed to get up off the toilet and opened the door a wee bit, I couldn’t see anyone and then I saw a lady in her bed opposite and said could you ask the nurse to come and help me up. Well you know I sat there for 20 minutes before anybody came ..... I was maybe passed myself.....they had forgotten and I thought oh dear what will I do if I am stuck ..... You think the daftest things you know”... “They would forget you see. They would say oh I will be back and then conveniently forget.”*

The use of this final statement from the respondent seemed to suggest she interpreted this experience of poor care as a deliberate approach by the nurses, although not as a personalised act rather as a means of ignoring the work demand.

It is possible that nurses use responding to call bells as a means of controlling patient interaction, emphasising their busyness or as a means of maintaining their power relationship with the patient. Tarlier (2004) suggests that nurses subtly and instinctively use power relationships in their care of patients, but this is not acknowledged nor well understood and is seldom addressed in the literature. One suggests that this lack of acknowledgement of power relationships reflects the societal held notion that nurses should be caring and good (James 1992, Staden 1998, White 2002) and therefore, nurses would not abuse their position of power in this way. However, this issue of power relationships in nursing offers an area that has potential for further study.

A second unfavourable activity identified by participants in terms of other patient's behaviour was the patient making unnecessary demands of the nurses; such as, expecting cups of tea when the person wanting it was able and ambulant, and, therefore, in the eyes of the respondent, being unreasonable in asking for it rather than going to get one from the canteen. This issue of being able to leave the ward, although not overt within the data, raises a dilemma for patients in terms of acceptable behaviour and the need to ask permission to undertake a legitimate activity. This fits with Irurita and Williams (2001) notion of the requirement of 'knowing what to expect' as a means of preserving integrity. Participants did not feel they could leave the ward and therefore, it did not seem to occur to them that this was an acceptable activity if they were fit enough to do

so. They did not ask the nurses whether this was possible nor did nurses suggest it to the patients as an acceptable behaviour. This lack of activity or change of scenery seemed to have an impact on the participants' recovery from illness. One respondent noted that she used to be an active person, doing her own gardening and walking a lot, but now she was a bit shaky on her legs because she was not getting any exercise and had taken herself for walks up and down the short corridor in the ward as a means of achieving some exercise. She had not realised, and none of the nurses had suggested, that she might leave the ward and go for a longer walk or to the coffee shop.

*Pt9AMC "Well I used to take walks up and down the corridor but it took me a few days to get the use of my legs back because I am really quite an active person. I mean I do all my own garden, I don't have any kind of help you know. And I cook for myself and shop and everything like that."*

The participants all remained in the ward area during their hospital stay unless they were taken somewhere by a visitor or health professional.

*Pt14AMC "I like the physiotherapist....big long walks they gave me, and at the end of it a long corridor.....one took me around outside one of the times"*

*Pt7AMC "I use that walking stick and I go out when it is muggy. You weren't able to do that in the hospital."*

It seemed that the participants did not expect to be anywhere during their stay apart from the ward or places concerned with their treatment. Potentially, participants had assumed,

or learnt from previous experiences of care that this was not something that you did as a patient. In terms of 'knowing what to expect' it is unclear where this knowledge about not going out comes from but participants did not ask the nurses whether they could go out, nor did they seem to expect to be able to. This may have been because the participants presumed that because they were in hospital they had no option regarding this or because they perceived the nurses as busy and felt that by asking the nurses might feel incumbent to take them out. Certainly for those participants who were only in hospital for a short period it may not have been a major issue. However, it could affect the recovery of those who had been in for any length of time (some were in-patients for 2 months).

Unless the respondent had been a patient in hospital in the recent past, and had, therefore, learnt what to expect, there did not appear to be any effort made by nurses or others in the care context to assist patients in knowing what to expect. A major element of the negative experiences identified from the data related to lack of information, and this was compounded in this respondent group because they were unlikely to ask about things or challenge issues of care.

For example, one respondent, who had an intravenous infusion pump running, attempted to go to the toilet but no-one had told her about the need to unplug the machine first and she became 'all tangled up as there was a lot of wire'. This was a very negative experience for her to the extent that she blamed herself for her lack of knowledge rather than expecting the information to be given to her by the admitting nurse.

*Pt9AMC “Oh no, I was very ignorant when I first went in, in the March.....and I think in one of my notes I read it said this lady had difficulty with the.....whatever you call it (infusion pump). Anyway you learn as you go along, and I suppose most people had been in hospital, that they know about all these things.”*

Due to this lady's personality and independent approach to life, she was able to laugh about this and other negative incidents in her care, and made sense of them by making assumptions about other patients' experiences, comparing her experiences to previous much earlier childhood experiences of hospital care and relating experiences to her upbringing which influenced her expectations. The issue of self-criticism arose with other participants and this will be addressed later in Chapter 7: Person-orientated experiences of care.

The desire to actively recover, another of Irurita's (1996) elements in maintaining integrity, also emerged from the data as part of role acceptance. Participants identified that they had a duty or part to play in their recovery in terms of undertaking treatment, behaving in an appropriate manner and assisting themselves to get better. One respondent, who had been admitted to hospital with a minor stroke and high blood pressure, had managed to give up smoking '*all because she went into hospital*'. Another who wanted to go to bed, but knew that the nursing staff were busy, decided to try and get undressed by herself.



*Pt2AMC “I thought, well just have a go at getting undressed yourself. So I went and sat on the bed and got my clothes off and got into my nightie and then I buzzed... and somebody came...oh I said no I can’t get into bed by myself but I can manage quite a lot.*

Another respondent Pt3AMC indicated that she was in the ward to do a job – that was get back on her feet, and she was doing this by using the aids , trying different approaches to doing things and doing what she was told by the physiotherapists. She felt she should concentrate on trying to get better as she was in hospital and therefore, she had a role in getting better and achieving her discharge home.

Again participants commented negatively about other patients that they felt were not taking an appropriate part in their care.

*Pt6AC “he was told not to smoke and he wanted to smoke and he tried umpteen times in the ward.....it is like in Wd- I was absolutely flabbergasted ... people walking about hooked up to machines for chemotherapy puffing away at their cigarettes.”*

Similarly, this respondent commented that he thought a lot of people went in with the attitude that the hospital staff were there to look after them and that the staff should do this and do that in terms of their care. Interestingly, this respondent identified that this attitude prevailed amongst the younger patients in the ward, and there may be an element of change expectations in the younger generations in society. The previous research referred to in terms of preserving integrity had sample groups that consisted of older people, therefore this element of taking part in care to actively recover might reflect only this generation’s views regarding preserving integrity (Irurita 1996, Irurita and Williams 2001, Koch et al. 1995, Webb and Hope 1995). Similarly in Coyle and

Williams's (2001) sample, over one third of the sample group were aged 65 and over, which might also explain their results relating to this aspect of care.

The third element relating to preserving integrity identified through the work of several authors, that of the development of a nurse-patient relationship will be addressed in Chapter 5: Patient's interactions with nurses (Irurita 1996, Irurita and Williams 2001, Koch et al. 1995, Webb and Hope 1995).

This role acceptance by participants appears to assist them in being unconditionally accepting of their health care provision even though within the care experience they had, had negative experiences of care. Williams et al.(1998) found similar results in their research with mental health patients. Although the participants were positive and unconditionally accepting of their care they did have some insightful criticisms to make, and this forms the final coded category, that of criticism of the care culture.

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### **Criticism of the Care Culture**

This final category was included as it highlighted that the participants were aware, and accepting of, issues that affected their experiences of care in a negative way. Although participants universally affirmed that their care was good, data analysis revealed all participants to be critical of the care culture, in terms of organisational issues. No direct research has been found regarding patients' knowledge and understanding of the organisational aspects of acute health care. Koch et al.'s (1995) work in acute care of older people wards highlighted that organisational and contextual aspects of care impacted on the patient experiences, however, their study did not explore the patients'

explanations of their experiences. This, therefore, means that the participant's knowledge and ability to explain how the organisation was affecting their care experience in terms of staffing issues and management of care, identified through this research, is new knowledge.

The participants identified several organisational aspects of their care which had impacted on their experience. These can be clustered into broad categories of issues relating to staffing, and those that relate to personal issues, such as meals, boredom and visiting times.

Criticisms in terms of staffing related to issues of staff management, staff attitudes, and shift patterns. The participants indicated that there was a lack of consistency to the allocation of nursing staff involved in their care which participants identified as causing a lack of continuity to their care.

None of the participants was able to identify a named nurse allocated to their care, which given the Governmental agenda regarding this strategy, was interesting (Department of Health 1999). Perhaps more important to note was the fact that the participants did not see this as an issue and were more concerned with the nurse having the skills and experience to care for them.

*Pt8AC "I mean you didn't get their names or anything, they were just in and out. They did chat to you... the mornings they would speak to you about 2 or 3 times and that was it because they don't have any time."*

*Pt9AMC "Well I was quite happy with just whatever nurse was available."*

*Pt2AMC "They were all nice girls but different people each time"*

One respondent noted that there were not always the same nurses on your side (*of the ward*) and that she was surprised that nurses worked such long hours, however, she noted that these nurses were only there for a short time, not long enough to get to know them.

*Pt4AMC “ They work long shifts, and the nurse might be on for 3 days but then they are away for 4 and you can be gone by then, or they are sent to work somewhere else”*

*Pt8AC “There was no special nurse, too many of them for that”*

*Pt10AMC “there is not the same continuity because of the 12 hour shifts”*

This reflects the 12 hours shift patterns used in the majority of the wards sampled. One respondent's perception was that nurses were changed a lot from ward to ward. On closer questioning what appeared to be happening was that nurses were allocated each day to a bay of patients in the ward; and every day different nurses were allocated to each bay to work so there was no continuity of care from a specific nurse caring for the same group of patients over a period of days. This lack of continuity of nurses clearly would impact on the ability of the nurse and patient to develop any meaningful relationship or interaction.

This lack of continuity of care did not seem to be an issue for the participants. Comments from several indicated that nurses were potentially seen as a homogenous group and that as long as they were qualified nurses the care would be correct. One respondent (Pt5AMC) commented on the fact that nursing auxiliaries were being trained

to take blood pressures, and this seemed to concern her, although she justified it by saying *“I suppose they pick the ones that can do it”*.

These points will be readdressed in the Chapter 6: Patient’s Interactions with nurses.

Other issues that participants made critical comment about were those that were organisational aspects of care such as meals, cleaning, boredom and personal effects.

Several participants were not overtly critical of the food served in the wards; however, by their comparisons with other experiences of care, criticism was implied. Participants appreciated the ability to choose their meals; however, this choice is really controlled by the organisation in terms of patient’s wishes. As one respondent noted:

*Pt2AMC “ they would come the night before and say now choose your breakfast, lunch and your tea, and sometimes you didn’t want what they were offering at lunch, or you did not feel like that food when it came the next day.”*

*Pt4AMC” We got menus and the food was good. The food was good in W.....whereas at the R.... it was dreadful. They reckoned the food came up from Wales and I mean that was ridiculous.*

Similarly, participants were aware and accepting of the fact that the hospital was catering for large numbers of people and therefore the food was not going to be that good.

*Pt 9AMC “No I thought the food was excellent and yet I have heard and read quite a bit of people complaining and I wondered why because I thought it was probably a lot better than people were making for themselves”*

*Pt1AC “I must say the food was extremely good, when I say extremely good, I mean for where we were, institutional feeding, I think things like the choice was also quite good”*

*Pt6AC “the food in the hospice is absolutely fabulous, but they said they are only catering for a small number of people, that includes the volunteers and staff but not to the extent of a hospital.”*

This particular patient had experience of being in another large hospital in the city, and was able to compare the meals between two institutions as well, with his current ward and hospital being seen as much better in the respect of food.

This ability of the participants to use their knowledge and experiences of other situations to rationalise the care culture seems to be one of the ways they make sense of their experiences.

Perhaps unsurprisingly, given the recent high profiling in the media, the issue of cleaning on the wards was raised as a criticism of the care culture. One respondent identified that:

*Pt10AMC “ hygiene was very poor, not much hand-washing and the toilet in my 4 bed unit was only cleaned twice during my stay (of 8 days) Nurses do not seem to see cleaning as part of their job, nobody seemed to take charge of anything”*

This respondent continued to tell of how eventually one of the other patients in the bay had cleaned the toilet because the cleaner who mopped the floors did not do toilets and said she would tell someone else. Similarly another respondent, in relation to cleaning, exonerated the nurses from this aspect of care, suggesting it wasn't their fault it was the systems and that if we went back to having matrons who had overall charge of everything to do with the wards things would be better.

Again participants compared their experiences of cleaning to previous ones, and also their own expectations of the cleaning. One respondent who had not been in hospital since she was 10 commented on the difference in the cleaning.

*Pt9AMC “I mean there was a nurse with a great big mop who polished the floors, you don’t see that today.”*

Another offered to move away from his bed so the floor could be cleaned but the cleaner said it was alright and cleaned around about the area. This respondent had expected the beds, chairs and other furniture to be moved to allow the floors to be cleaned.

Other criticisms related to assumptions made by the organisation and through implication the nurses, about individuals having people (family and friends) to rely on in relation to getting clean clothing and other necessities. One respondent, who had no family nearby and had been admitted from a residential home, had no clean nightwear to change into.

*Pt2AMC “I said well I haven’t any nighties with me and the hospital said oh we don’t wash nighties”*

This respondent ended up wearing an operating theatre gown as a nightdress, which she laughed about but also commented:

*Pt2AMC “What are you supposed to do if you are in hospital and maybe got no-one to look after you?”*

The interesting thing about this situation is that the respondent quite clearly avoided blaming the nurses for this situation regarding washing of clothes, by referring to the hospital as not washing nightdresses. It is an important point that is being made here about assumptions that are made by an organisation in relation to their responsibilities regarding the people in their care. The residential home the patient normally stayed in perceived no responsibility on their part, nor did the hospital; and although the respondent was given something to wear it was far from adequate, and the inference made was that she should sort the situation out herself somehow.

Another similar example of this is the issue of visiting times, with several participants commenting on the restricted hours for visiting, although they acknowledged the possibility that this was necessary for patient treatments or rest times.

*Pt14AMC “No you can appreciate that the nurses and doctors have got things to do and they need the time as well you know. They cannae have Joe Bloggs tripping in every 10 minutes you now...”*

However, they noted that this meant there was an excessive demand on the relatives in terms of visiting in the afternoon from 3 – 4.30pm and then returning for visiting at 6.30-8pm, often meaning that the relatives had barely been home before they came back to the hospital. This organisationally imposed restricted visiting, was however, circumvented in certain situations with the ward manager giving permission for differing visiting scenarios for some patients. Respondents’ relatives negotiated access to deliver basic personal hygiene accoutrements out-with visiting hours or in certain situations to



assist with feeding or keeping the respondent company. This was recognised by participants and their families as being a special arrangement and it was explained by participants as being a means of assisting the nurses in their work, otherwise the patient would not be fed as the nurses would not have time to feed them.

The final issue was that of boredom, with participants indicating that the lack of any activity other than watching television or reading made the time pass very slowly. The lack of activity seemed in some cases to hinder the participants' ability to recover.

*Pt5AMC "When you went in you felt it was grand. But when you had been in a while it gets a bit boring."*

*Pt9AMC " when I got home, I was a bit shaky on my legs but I think that was because I wasn't getting any exercise I was just by the bed all the time. Well I used to take walks up and down the corridor but it took me a few days to get the use of my legs back because I am really quite an active person. And I think you know lack of exercise is a very bad thing. I think you have to use your body or it gives up on you."*

Participants acknowledged that there were some activities available to them such as watching television, reading papers or chatting, but no effort was made to encourage them to take exercise or activity. This is similar to the situation commented on previously in role acceptance.

## **Conclusion**

The results from this chapter demonstrate that participants, although they have universally affirmed that their care experience was good, have in fact, had negative experiences of care. These they have been able to make sense of and explain using

comparison to their previous experiences. However, if it was a first admission to hospital, the participants relate their experience to previous knowledge of care prior to the instigation of the National Health Service. Participants also contrasted their own experience of negative care to extreme examples of poor care identified in the media; and were thus able to rationalise their own situations into being adequate or good because of the extreme cases highlighted elsewhere. There was no criticism of nurses, who were universally acclaimed to be wonderful, caring and helpful, although participants did identify that some were much better than others. Participants justified their care and absolved nurses from blame, by acknowledging organisational demands and the need for routinised care to allow wards to function. They also justified their care in relation to their perceived health status.

The participants' acceptance of their care was mediated through role acceptance to make sure their stay in hospital was tolerable; although issues of control and powerlessness appeared covertly in the data. These aspects were contributed to by lack of information and assumptions made by nurses regarding the patient's knowledge of how to behave. Final elements in the participants' responses to the care situation were their criticism of the care context in relation to organisational and contextual aspects of care. Staff issues such as lack of continuity of nursing staff and therefore no development of a relationship; along with hospitality issues were noted and rationalised.

The participants' universal acclaim of the nurses may have resulted from the nature of the nurse/patient interactions and this aspect of the patients' experience will be addressed in the next chapter, along with the issue of what makes one nurse more acceptable as a carer than another.

## **CHAPTER 6**

### **PATIENTS' INTERACTIONS WITH NURSES**

This chapter addresses the second major way patients expressed their experiences of care: through the nature of the patient's interaction with nurses and the nature of their relationship. The chapter will analyse the development of the interaction/relationship and explore the participants' explanations of their experiences within this. During the data analysis it became apparent that several aspects of the patient/nurse interaction were significant. These categories were; nurse accessibility, time related issues and the maturity of the nurse.

#### **Nurse accessibility**

Participants identified that nurse accessibility was an important factor in making their care experience a positive one and that they expected to see nurses in the care environment. This confirms Moyle's (2003) results where patients had an expectation of nursing staff always being visible even if they were not actually directly working with the patient. This issue of accessibility/visibility made the participants feel confident that help was available should they require it, and this visual contact meant that nurses were seen as a reassuring presence even though they were not directly involved with caring for that patient. This concurs with Coyle and Williams's (2001) work which found that being able to visually locate nurses reduced patients' anxiety, and this seemed to assist the participants in viewing the nurses in a positive way, again confirming results

identified by Attree (2001a) who noted that patients were complementary about staff who were accessible.

*Pt4AMC “We saw the nurses, they were always up and down the corridor you know”*

*Pt9AMC “so I could see the nurses going down the corridor again”*

*Pt8AC “they were just on the ward and you had a buzzer, and you could buzz if you needed something”*

Participants, in the main, were less concerned with having a named nurse or even the same nurse looking after them during their stay. It appeared that participants saw nurses as a homogenous group who delivered appropriate care when they needed it, to the extent that participants did not know the nurses’ names, and sometimes did not know their status either. This reflects Salvage’s (1990) questioning of whether patients want or require one to one relationships with individual nurses or whether they, in fact, want some form of relationship with nurses as a global group. Similarly de Raeve (2002) suggests that the short term nature of the patients stay in hospital means that patients place their trust in the homogenous organization and its nurses rather than individual nurses.

*Pt9AMC “well I was quite happy with just whatever nurse was available.” “Oh I got terribly mixed up. I saw so many different nurses I was having difficulty getting the right names all the time”*

*Pt5AMC “they were all more or less the same, just as long as they were doing a good job.”*

*Pt3AMC “felt well cared for, but there was no special nurse, too many of them for that.”*

*Pt14AMC “you just got used to the different ones you know.”*

Several previous studies have indicated that patients wanted social relationships with the nursing staff and that these assisted patients in expressing their worries and anxieties (Attree 2001a, Hallstrom and Elander 2001, Webb and Hope 1995). Similarly recent research has been focussed on the nature of the nurse-patient relationship and its therapeutic effects (Crowe 2000, Forchuk 1995, Kelly 2005, McQueen 2000, Moyle 2003, Olsen 1997) with Williams (2001b) asserting that the nurse-patient relationship is central to patient health, well-being and recovery.

Interestingly the data from this study did not reveal this aspect of care to be of great importance to the participants. Although several participants knew more about some nurses in terms of them as people, none of them felt this had a particular impact on their care experience and they did not see it as being an important aspect of the care experience. Even participants who had had an extended stay in hospital did not have a detailed knowledge or relationship with the nurses. It may be that the participants, as Salvage (1990) and de Raeve (2002) suggest, are happy with a relationship with nurses as a global group and did not expect or feel the need for a closer relationship with specific nurses. Potentially this issue of developing a relationship with particular nurses may be more important depending on the length of stay of a patient in hospital. This area would require further research to establish whether the relationship between patients and nurses is important to the patient experience and recovery.

The need for personal interaction with nurses could also be influenced by the personalities of the sample group and also by their age and home situation. Some

participants enjoyed the fact that there were a lot of nurses involved in their care, as they had different people to talk to and interact with, but they did not see this as developing a relationship. It may be that these participants were living alone and had little social contact when at home. Therefore, getting to know a little about the nurses and their lives would be of benefit for them. However, given that the participants also indicated the boredom related to being in hospital, it may be that they used this discourse with the nurses as a way of relieving the boredom, and passing the time. This could only occur when the nurses were not perceived as busy, and so was limited as a means of social interaction. One participant identified that the only time that seemed to be available for the nurses to sit and chat with them was just before the night staff arrived late in the evening. The notion of the organisation perceiving nurses as being interchangeable was identified by Morse (1991) who indicated concern with this viewpoint, and argued that in the caring relationship caregivers are not, and cannot be interchangeable. However, from the data in this research it would seem that participants also see nurses as interchangeable, and therefore potentially do not experience the need for a caring relationship.

*Pt3AMC “not really interested in having a strong relationship with my nurse, I had no real relationship just a chat about bits and pieces”*

Personality also seems to have an impact on the interactions between nurses and patients. One participant, in discussing her interactions with the nurses, indicated that it was difficult for her to talk to them as she was not a person who opened up easily and

liked to keep herself to herself, although she felt more comfortable with some of the more mature nurses.

*Pt4AMC “ yes some of the nurses were as I say easier to talk to, some of the more mature ones but it was difficult and I am not a person to open up very easy.”*

Morse (1991) notes that the patient has control over factors that will increase and decrease the rate and level of a developing relationship. One technique being to share less information about themselves, and keep conversation focussed on professional concerns. This control over the interaction is seen as an important means of maintaining personal integrity and therefore, nurses should not expect or require the patient to participate in interactions (Coyle and Williams 2001, Irurita 1996, Irurita and Williams 2001). How the nurses identify which patients wish to be involved in interactions is addressed in Chapter 9: Nurse Relationships in the Care Situation.

One particular participant, (Pt6AC) a male, gave a detailed account of how he felt it was important for the patient to make an effort to interact with the staff, even if you could not always be bothered. This was because he felt that they were there to look after you as a patient and if you made the effort they would respond in kind. When asked whether personality and being outgoing affected the nature of the relationship, he agreed that might be part of it but also noted that he reacted better with women, and therefore, one might suggest that as most nurses are women this could explain his particular positive approach to the relationship. It was obvious from the interview data that this patient had been in the ward several times for reasonable periods of time, and seemed to have

developed a special, shared relationship with the nurses there. This was anomalous in relation to the rest of the data collected but could be explained by work from Olsen (1997) who noted that nurses preferred caring for patients who were cheerful, dependent and communicative. It could also reflect the issue referred to earlier relating to length of stay, or in this case repeated stays for short periods in the same ward.

A participant's lack of relationships with any nurse could, however, have a detrimental effect on the care that patient receives. It is possible that this global grouping of nurses could allow for poor nursing practice to go unreported or noticed, as participants would not assign responsibility for any specific aspects of care to a particular nurse. Similarly it may affect the quality of care offered by nurses, who, because they are not seen as individuals, and therefore do not receive positive feedback in terms of their relationship with the patient, are less concerned about, or involved in delivering a quality product. Moyle (2003) suggests that nurses require positive feedback from patients to feel satisfied in their role. This issue of positive feedback will be addressed in the nursing chapters.

Potentially, length of stay or numbers of stays in hospital will have an effect on the patient's development of interactions and relationships with nurses. The coded category of time-related issues was identified through the participants' data.

### **Time related relationships**

Participants clearly identified several issues that militated against development of a relationship with the nurse. Although maintaining that they did not require a meaningful



relationship, participants suggested that development of a meaningful relationship was futile due to the limited time that they had with any one nurse.

*Pt4AMC “they couldn’t spend so much time with you and I seemed to be either down at X-ray or getting that tube put back up my nose”*

*Pt3AMC “I got on better with some nurses- those you saw more often. There were lots of nurses but I was not really there for long enough to get to know them”*

One participant compared the experience of lack of time to talk to that of going to her doctor’s surgery, where they do not have time to talk about what is wrong with you. Again there was a use, by participants, of previous experiences of health care to explain and understand the situation the participant was currently in.

The use of long shift (12 hour shifts) working meant that the participants often saw a particular nurse for one or two days before the nurse had days off duty, and then the participants were often discharged before the nurse returned on duty. Other aspects of the long shift could cause difficulties, as the nurse who admitted the participant, and who therefore got the most detailed knowledge about the person, could well be off duty for the next three days by which time the participant was either going home or had been discharged. The following comment was made by the participant who had repeated short stays in one ward as previously mentioned on page 209.

*Pt6AC “I think as well if people are just in for short stays they don’t really have time to have a relationship with the nurses.*

Similarly, the nurses' were not routinely working with the participants each day, so that, although a participant had perhaps two nurses allocated to their bay for the day, it would be different nurses allocated every day so no continuity of staff was available and thus it was difficult to establish a relationship of any sort.

The participants identified the roster system through observing the nurses on-duty patterns and recognised that this did not give continuity of care, with one commenting on overheard discussion between nurses who had been off for several days where the nurse had said she did not know what was happening because she had been off. Although McQueen (2000) identified that this shorter contact time between patients and nurses limits the formation of good rapport at a time when there potentially is a need for increased support, this lack of continuity did not appear to affect how the participants experienced their care situation. This result is in direct contrast to that of Hallstrom and Elander, (2001) who found patients ranked continuity of staff highly. This difference might be explained by the fact that participants, as noted earlier, saw nurses as a homogeneous group rather than as individuals and thus were interchangeable in terms of the care they gave.

*Pt2AMC "It did not bother me really, there was not really much consistency, no there was different ones."*

*Pt9AMC "well I was quite happy with just whatever nurse was available."*

Participants also identified that they personally did not attempt to draw the nurses into conversation unless the nurse was doing something with them at the time. This was

because they perceived the nurses as being busy with other patients whom the participants saw as being more ill and therefore, more worthy of the nurse's attention.

*Pt9AMC* "I was obviously more physically able than the other 3 and I really didn't need a lot of attention...one was in bed all the time you know and needed a lot of attention."

*Pt8AC* "I mean you didn't get their names or anything they were just in and out.....oh aye, they did chat to you, mostly it was just when they were in doing something in the mornings, they would speak to you two or three times."

Participants also explained that they felt that the nurses would spend time with them when they had the time, but because the nurses were busy they just didn't have the time. One respondent identified that the time between 8pm and 8.30pm at night, once all the patients had been settled down was a time when the nurses would stop for a chat.

It seems that these participants were accepting of the constraints that time had on their relationships with the nurses and did not seem to need or see the benefit of the opportunity to develop an intimate relationship. This notion of the benefit of a close relationship is an area which Williams (2001a) identified as needing answered.

Finally participants identified the issue of maturity of the nurse as affecting their relationships and experiences of care.

### **Maturity of the nurse**

The final issue identified by participants, in relation to their interactions was that of the maturity of the nurse. This did not always relate to chronological maturity, rather more to the maturity of the behaviour and approach the nurse used. Participants were

interested and keen to explain why they identified some nurses as caring and others not. A particularly clear example of this is illustrated in this extended segment of interview.

*Pt4AMC “some of the young ones were a wee bit harem scarem but the wee bit older ones you could talk to.”*

*Inter “so the more mature ones maybe?”*

*Pt4AMC “I mean the young ones were alright too, I’m not saying...but you felt that sometimes they were just out for a lark”*

*Inter “can you give me an example of that, which made you feel that?”*

*Pt4AMC “well there was some of the nurses...some of the young nurses they were very squeamish.”*

*Inter “oh really”*

*Pt4AMC “really squeamish and one actually had to come out of being with somebody that had maybe soiled themselves and they had to really walk away, and coming out baulking you know, and that was young nurses.”*

*Inter “did you find that strange?”*

*Pt4AMC “I found it very, very strange because the simple fact that ...you would expect that nursing they would expect to have to deal with that sort of thing.”*

Other participants noted that some nurses just seemed to see it as being a job.

*Pt6AC “I just got the impression that they weren’t very dedicated, they were just sort of there for.....well this was a job.*

Participants found the nurses who were more recently qualified (and potentially younger) to be less professional and skilled in undertaking unpleasant tasks. An explanation for the differences in behaviour noted by participants may be to do with the

issue of the maturity of the nurse in terms of their professional development. It seems to relate to the moral development of the nurse in being socialised into the professional self, and subscribing to the generally accepted norms and values of the profession. Sumner (2001) suggests that the neophyte nurse employs strategic action to conform to the norms of practice, and without question is obedient to the organisation. More mature experienced nurses are able to function autonomously and react appropriately, and are able to react on an emotional level with patients. This was experienced by participants who identified that more experienced, and hence mature, nurses were able to share of themselves but not be too familiar in their approach. Similarly the participants recognised that this was a skill; how to interpret what the patient was wanting in terms of interaction, and that it might take a few years in nursing to develop it.

*Pt6AC “maybe it takes a few years to realise that. You know if a patient is feeling down, you don’t go in all so boisterous, or that you know if the patient needs that type of thing to bring him out of his self.*

Participants also identified that these mature nurses did what they said they would in terms of returning in a specified period of time, or getting things for the participants. These actions are what Brilowski and Wendler (2005) identify as being part of a caring nurse through presence.

Participants clearly had an expectation that nurses behave in a certain way which includes professional comportment and demeanour. When this idea was explored further with participants they were unable to identify how or where their idea of professional behaviour had stemmed from. One participant compared the hospital nurses’ behaviour

favourably, to that of a nurse from overseas who worked in the care home. The overseas nurse behaved in a manner that the participant felt was less appropriate. It may be that inherent within the participant's understanding of nursing there are societal based norms and values that inform their expectations. Any difference between participants' expectations and the reality of their experience may stem from a difference of perspective between the nurses and participants, in terms of the norms and values of nursing care (Sumner 2001).

This possibly arises from societal expectation, identified by White (2002), that nursing frequently means undertaking unpleasant tasks as part of the vocation of nursing. However, some nurses may not subscribe to nursing being a vocation and to them it is just a job. Other participants identified this notion of vocation as well, seeing certain nurses as being really dedicated to their jobs. This was illustrated by participants indicating that although the nurses might have had a difficult day the previous shift, they still came in smiling the next day.

*Pt6AC "it's the way they keep smiling. They do don't they...You know they can have a real stinker of a day one day and then come in the next day and they are still smiling. You know it's unbelievable. They are definitely dedicated."*

Participants further explained their good experiences by suggesting that nurses are specifically selected, by personality, to do the job. Again this expectation regarding a nurse's disposition seems to be established from the societal view that nursing is a vocation (White 2002).

*Pt9AMC “I sort of got the feeling that they were there because of their personality”*

*Pt10AMC “it’s something to do with the personality of the nurse”*

*P9AMC “I did wonder if the nurses there were chosen for their personalities rather than skills”*

One participant described how a student nurse was like a lost soul, and they felt they could have told her what to do, and they were not sure that she was going into the right profession because she seemed so quiet and timid. Another identified the type of personality they felt a nurse should have.

*Pt6AC “I think you have got to be quite an outgoing sort of person to deal with what you are dealing with when you are nursing. If you are dealing with members of the public you have got to be able to communicate, you’ve got to be able to talk to people.”*

## **Conclusion**

Overall, participants were happy with the nature of the interactions and relationships they had with the nurses and did not feel that a closer relationship would be of benefit. By using ideas from close observation of the situations that were occurring in the ward, or through personal experiences, and comparison to previous experiences, participants were able to devise a reality of care that reflected their experiences.

The ability of nurses to develop varying forms of relationship with patients was explained by participants through the notions of dedication, vocation and personality along with maturity of experience in nursing.

The participants have explained their care experiences in terms of the contextual situation of care and also through their interactions in that situation. The following chapter explores participants' perspectives of the actual care delivered in terms of them as individuals.



## **CHAPTER 7**

### **PERSON-ORIENTATED EXPERIENCES OF CARE.**

This chapter addresses the nature of the patient's experiences of care in relation to the notion of person-orientated care. The aim is to explore participants' experiences of care through the identified theme of person-orientated care. Although several previous studies (Irurita and Williams 2001, Koch et al. 1995, Redfern and Norman 1999a, Redfern and Norman 1999b, Webb and Hope 1995, Williams 2001a) identified a core theme of 'desire for individualised care', this element of desire was not reflected by participants and the notion of person-orientated care was deemed more appropriate as it reflected the ideas identified by participants. Elements relating to the notion of individualised care can be found in the data, however, within this theme, participants' responses were coded into three main areas, those of non-facilitative care, decision-making, and self-determined care, as these more clearly reflected the results.

#### **Non-facilitative care**

This category was never overtly identified by participants but was implicit in the examples they gave of care they received. The notion of non-facilitative care reflects several aspects of nursing care that were less than optimal and contrary to the ideal of patient - centred care and patient involvement; often these episodes related to information giving or lack of it.

All but two participants gave examples of what could be classed as non-facilitative care experiences, these mainly related to nurses working with respect to organisational demands rather than being patient orientated. One participant spoke of an occasion when the nurses were late in getting to her to assist her to get up (this finally occurred at 11 am); and she was getting anxious and wondering if she had been forgotten, however, she explained that the situation must have occurred because the nurses were busy. Another wanted to get dressed as she preferred to be in her own clothes but no-one was available to help her. Others commented on having to get up early every day because the nurses changed the beds every morning.

*Pt2AMC "I am quite keen.....I mean I am not daft...but I want to get dressed in the morning"*

*Pt5AMC "You would get up at 7am, then you would get your breakfast at 8.30, and they got you up and washed for breakfast."*

This data compliments that of Attree (2001a) who found patients commented on the routine nature of care and how it was unrelated to need. Participants accepted these care scenarios as being part of large organisation. They explained that these situations occurred because the nurses were busy, that there were not enough nurses and that there had to be a routine in the ward otherwise the organisation couldn't function effectively.

*Pt9AMC"oh that was all pre-planned and I would think it would have to be like that in the ward. It was an early start and breakfast was at a certain time...well I expected that because they have got to work to a strict timetable I imagine"*

*Pt2AMC “they came round at a certain time with pills, and they came round and got you water, took you for a shower but .....but well they were too busy really to be asking you and changing the plans”*

The use of call bells and the time taken to respond to these also contributed to non-facilitative care. Participants again, accepted and explained this by indicating that they knew someone would come eventually, and that they felt the nurses must be dealing with someone who was sicker or needed more immediate care than they did; so they were prepared to wait. Participants clearly believed that they should only make requests with good cause and because of this perception it can be suggested that care expectations were limited. These results concurred with those found by Macduff (1998), Coyle and Williams (2001) and Shattell and Thomas (2005).

Often participants found their attempts at being self caring sometimes thwarted by the nurses. This appeared to occur because the nurses and doctors made assumptions about the respondent's abilities. One respondent who had had a surgical operation and was now able to have a bath independently was frustrated by nurses walking behind him on the way to and from the bathroom. He explained this by saying

*Pt8AC “I think a lot of the nurses maybe think you are a wee bit unsteady”*

Often participants found themselves being assisted to undertake personal care that they were able to do themselves. They suggested this might be because, as older people, it is assumed that they cannot manage or that nurses did things for them because it was quicker and thus met the demands of getting through the work.

*Pt2AC” I think they think a lot of the older people are like that (requiring personal assistance) and in hospital they came and washed you even if you wanted to have a shot yourself. I can wash my face and my arms and under here but I can’t do my back.*

These assumptions resulted in participants being constrained in their self-care attempts because the nurses did not ask them whether they could manage and thus this may have had an impact on the respondent’s desire to participate in care and their recovery times. This behaviour by the nurses also thwarted the participants’ attempts to assist in their recovery by actively taking on the role of assisting in getting better as identified by Irurita (1996).

Non facilitative experiences that were associated with information giving were remarked on by participants, and these often related to issues of treatment, admission, visiting hours or discharge: all aspects of care which could have a major impact on the patient’s experience. Participants were concerned to find out about what was wrong with them, and what would happen to them, and when this information was not forthcoming they felt frustrated and anxious. One participant articulated that it would have helped her to feel that she was getting somewhere and would know what to do to get well. Thus again reflecting the expectations identified by Irurita (1996) and Irurita and Williams (2001) of participants having a legitimate role to play in their own treatment and recovery. By denying the participants this information, they felt they were unable to act and behave in ways that would continue to assist their recovery.

*Pt9AMC “It would have been helpful, in fact, because I was so anxious to find out what was wrong with me I think. I mean its bad enough that you are in pain and you are uncomfortable and the next thing but at least if you know what’s wrong with you. You feel you are getting somewhere.*

Participants indicated that treatment was given with no information from nurses or doctors as to why or its effects, and they did not feel they had a decision regarding the treatment. This occurred regularly in relation to drug therapies, but also to other treatments.

*Pt2AMC “I didn’t really know exactly what was happening. I sometimes think they don’t want to tell you very much but I mean to say after all I am old, It’s your body that’s being discussed you know. I would like to know what’s what.”*

*Pt4AMC “they put me on to ...I’m only taking two tablets...but no-one told me what the tablets are for or how they work or anything... the one in the evening, its not a sleeping tablet.”*

Similarly, information regarding discharge was controlled by nurses with participants being told they were to be discharged often on the day it was to happen, or the previous evening. Participants again excused the nurses’ behaviour regarding discharge, again implicating the organisation as being at fault rather than the nurses. They understood; from their own observations, discussions with nurses and other people’s experiences, that no fixed times were possible.

Participants also again acted to preserve resources for those they saw as more worthy, not taking up offers of ambulance transport and arranging their own. Some of this

behaviour was not altruistic but a means of achieving their goal of discharge quicker due to the difficulties identified by participants with the service offered by the organisation.

*Pt3AMC "I was offered an ambulance but I didn't want to take up that time unnecessarily, also I would rather know when I was going rather than wait for an ambulance."*

*Pt14AMC "Even a week before I got home I didn't know I was getting home. My daughter made up her mind, that if we didn't hear by a certain date we were definitely gonnae ask. But the doctor came round the day before that and I got thrown out".*

Participants did not seem to challenge or query this lack of information, often blaming themselves for not asking rather than expecting information as a right. The effect of this non-facilitative care caused participants to react in two ways. Some accepted the care, although it was a negative experience. This was possibly because they came from a background that expected doctors, nurses and the hospital to know what they were doing and be right, and therefore the participants did not question the situation. They also may have been working within the framework of role acceptance whereby participants felt it was their role to make an effort to get better and thus they did not question the care. Others actively sought out the information, even if it meant, as one participant put it, making a nuisance of oneself. This was seen as a risky strategy as participants were aware that nurses could then see them as difficult and demanding patients, and thus their care might be affected.

Finally the context of the care situation affects participants' experiences as indicated by Stockdale and Warelow (2000), so achieving a return home is possibly the most

important aspect of their care experience for these participants and therefore, they are less concerned with the lack of information.

For other participants the non-facilitative care was a frustration, this had the effect of making participants more self-determining in their care. This issue will be addressed in a later section. Non-facilitative care, due to organisational demand and nurse behaviours had an impact on the participants' opportunities for decision-making and choice in their care experience.

### **Decision-making**

The subject of decision making and choice was linked to whether participants saw the care as non-facilitative or patient centred. Several studies note that patients value the chance to participate in decision making regarding their care (Hallstrom and Elander 2001, Lauri et al. 1997, McQueen 2000, Walker et al. 1998).

Participants in this study identified as positive experiences the chance to make choices and decision albeit tempered by the demands of the organisation. Choice and decision making opportunities were seen as being offered in terms of meal choices, bath times, bed times and clothes.

*Pt1AC "I remember at some stage they asked me if I would let them cut off my shirt"*

*Pt5AMC "well they came and asked you if you would like to go to bed"*

*Pt6AC "you usually got to choose your menus and things"*

However, the decision making and choices were tempered by the organisational context and demands on the nurses, which participants were aware of. In terms of the issue of choice for meals, if participants were in for several weeks they noted that the menu became repetitive and boring and thus the issue of making a choice was seen as less relevant. They also were not able to dictate portion size, as the meals were all plated prior to deliver. This was a problem for some participants who did not have a large appetite, and felt guilty about leaving their food. Part of this guilt stemmed from their upbringings during the war, where food was in scarce supply. Some participants had expected a system that would allow for portions to be served rather than a plated service and thus they would be able to manage their own amounts rather than waste the food. This expectation arose from previous experiences and also from friends' previous experiences of hospital catering. However, all these issues were explained by the participants as being part of the situation in a large organisational framework and thus they accepted them as the norm.

Often the decision making was subconsciously affected by the nurse's approach to the participant, with hidden messages about when they wanted things to be done. For example, what was couched as a question for a decision was really not that at all.

*Pt3AMC "there was no discussion about my discharge, it was you can go home tomorrow, if that's all right"*

*Pt2AMC "I said a shower at 2pm... But it's not long since I was dressed. She said oh well we are going to be busy tomorrow, so.....I said- well if you are going to be busy tomorrow- but it means I'll have to be in my nightie...she said well you'll be all ready*



*for bed then. I thought I'm not that keen to be ready for bed, there's a bit about making your own decisions and things."*

Decisions were also seen as delayed due to the organisational context of care; one respondent was not discharged because the doctor was away in Australia for 3 weeks. Although the doctor had commented to the patient that she (the patient) probably wouldn't be there when the doctor returned, no decision was taken until the doctor returned and then the discharge decision was made instantaneously. Other organisational factors were seen to affect the ability of participants to make decisions regarding their discharge; these included the need to arrange alterations to the house, or ambulance requirements.

Participants were also aware that some of their choices or decisions could affect other patients and therefore, there was an element of negotiation involved in the process. Some felt able to make suggestion about their care but this did not necessarily result in a change of action on the part of the nurses.

*Pt4AMC "I would say to the nurse, open the window, the blinds were still down...open the window and get a bit of air through, but every time I asked someone would say they were getting a draft and it would have to be shut but as I say we (the nurse and I) did it in between"*

*Pt3AMC "they didn't mind if you made a suggestion, and they were willing to try different things, but I am not sure what would happen if I disagreed with the nurse."*

However, participants did not either wish to, or feel able to challenge or decline the negative experiences they had in terms of making decisions. Many participants articulated that they did not think nurses would accept decisions that were contrary to what should happen, particularly in terms of treatments and drugs.

*Pt14AMC “ they would never have accepted it I don’t think, but they would do it in a nice way you know...I got tablets in the morning and last thing at night.”*

*Pt7AMC “I couldn’t have said I don’t want to take my tablets or anything like that I felt I had to do it”*

*Pt9AMC “well the drug trolley came along and I suppose I just accepted. I didn’t question it.”*

This reflects participants views, discussed in role acceptance in Chapter 4, that patient’s had an obligation to behave in certain ways in terms of accepting the care, and also raises the issue of power again. Certainly, this generation may have felt unable to challenge the authority of the health professionals, and nurses used their role and position of authority as a means of preventing or managing decision making and choice. However, some participants may wish nurse’s to make decisions on their behalf, and this again seems to depend on the context the respondent is in at the time. Often when first admitted and feeling very unwell, participants did not wish to have to make choices and decisions.

*Pt14AMC “I mean at that time I couldn’t have cared less about it...”*

*Pt9AMC “no I think at the time I was feeling so ill I just wanted to sleep and didn’t mind what happened.”*

This reflects the work by Stockdale and Warelow (2000) who maintain patients' experiences depend on the unique circumstances surrounding each situation and caring is always defined by what is important to the patient at that time. The participants' acceptance of care may also be explained from results identified by Nordgren and Fridlund (2001) where, as long as patients trusted in the care provided by the nurses, they did not feel the need to take the initiative and were passive recipients of the care. As participants compare their experience of acute care with that of the other patients in their environment, whom they perceive as worse off than themselves, and also with the extreme experiences reported in the media, it may be that the care they receive seems trustworthy and therefore they are happy to be recipients of care rather than partners in the care. However, if de Raeve's (2002) premise regarding patients trusting in the homogenous organisation is correct, then any negative media coverage regarding the local trust will potentially affect the participants trust and thus their acceptance of the care experience.

While patients are being encouraged to be more involved in decision-making it would appear, from these participants that the level of opportunity for decision making is adequate for them and did not affect their overall perception of a positive care experience. Interestingly, in terms of priority Hallstrom and Elander's (2001) research showed that patients identified decision-making as the least important in terms of their care, and this is reflected by these participants.

However, where decision-making was seen as part of non-facilitative care and participants were frustrated by this, the participants actively took action to be self-determining in the care process.

### **Self determined care.**

Apart from discussion in nursing literature that attempts to define self-determination, little actual systematic research has been done to explore patients' self-determination Nordgren and Fridlund (2001). It is interesting, therefore, that this category emerged from the patient data relatively strongly. Participants utilised self-determined care as a means of driving their progress towards recovery, particularly when nurses were not available to assist or not giving information that participants felt was required in order for them to move forward in their care. Macduff (1998) suggests that 'do it yourself' care which can be equated to self-determined care, is a result of the patient's locus of control, where a patient with an internal locus is pleased to be independent, whereas those with external locus followed nurse's instructions in order to please the nurse. This argument may be rather simplistic as it does not explain the participants' attributes in this study.

Data suggested that participants behaved in both ways during their experience of care.

At times participants were very self-determining, asking for information about their care, trying to do things for themselves without being asked and taking decisions about whether or not to do things such as take medications.

*Pt6AC “I wanted to know the ins and outs of it.....what kind of screws and metalwork and where they got them from and how much they cost” and “I was asking him if I could see it...and he said are you sure...aye I would like to see it..... so he says right that’s the monitor up there and are you watching and he was putting the scope up through the nose.....feeding this thing down and he said right that’s the scar tissue but there’s nothing much there.”*

*Pt4AMC “but they had me on morphine and they kept saying to me if you are in a lot of pain just ask for it...but I felt that it might be too easy to go for that.*

*Pt9AMC “they took a liver and kidney blood test, now I haven’t heard that I have got any problem there so next time I see her (the nurse)I will ask what the results are.”*

However, some of these same participants were also prepared to be passive recipients of care and take on the patient role.

*Pt4AMC “they never explained what the effects of the drug would be”*

*Pt9AMC “I just accepted it as what was to happen, then trying to find out what was wrong. I didn’t ask.”*

It maybe that, in terms of information and involvement in care, participants were unsure of whether nurses would be able to answer their questions or not, particularly about drugs and therefore, did not ask in order to protect the nurses from embarrassment.

*Pt9AMC “ if I had asked would the nurses have been sufficiently knowledgeable to tell me what a particular drug did.”*

Linked to the notion of self-determination was that of self criticism. Several participants were critical of their behaviour in terms of not challenging, questioning or taking an active involvement in their care.

One participant talked about a situation where a student nurse and a qualified nurse spent ages taking her blood pressure several times, to allow the student to practice. She maintained this was because they knew she would not complain “*as some people would have complained*”. Another felt her recovery had been hindered by lack of encouragement to be independent and was critical of herself for not pushing herself earlier.

*Pt4AMC “I felt I should have started earlier, getting up and going to the toilet and...It’s difficult to say maybe I should have pushed the nurses myself... instead of waiting for them to suggest things, you know what I mean.”*

Participants again explained and made sense of the experience of self-determined care by alluding to having a role in the process of achieving good care, which fits with the notion of role acceptance. They also perceived that, by doing things without being told or asked to by the nurses, they would in effect be helping the nurses to achieve the tasks of care, which, because the nurses were seen as being busy, might not otherwise be possible.

## **Conclusion**

In exploring the participants' experiences of care, a theme of person-orientated care was developed. This encompassed the issues of non-facilitative care, decision-making and self-determined care. Through these three categories it becomes clear that some participants behaved in ways that made them feel as if they were contributing to, or in charge of their experience. This was a means of assisting nurses to get the job done, as by making decisions and taking actions themselves they reduced the demand on nurses' time. However, some participants were also self-critical of their lack of involvement and saw that as a negative aspect of themselves, whereby they were not trying hard enough to get well which was contrary to the ethos of 'playing the game' and wanting to get better. Much of their experience was affected by the context that the respondent was in at the time, where certain actions were undertaken because at that point in the care experience they were seen by participants to be important.

## **CHAPTER 8**

### **NURSES' EXPLANATIONS OF CARE WORK**

Having reviewed patients' experiences of acute care and explored their explanations of what occurred, it is also important to set their experiences in context with the main carers in the acute care situation. To this end the research also aimed to examine qualified nurses' experiences in relation to older people, in the context of acute care. The objectives were to examine how nurses define themselves in relation to caring for older people and to analyse how nurses define themselves with respect to their professional identity and socialisation within the organisational framework of acute care. This and the following two chapters explore the nurses' responses in relation to the care work they undertake and the factors that affect the work, and the nurses themselves in terms of their expectations of care and organisational demands. Through coding and categorisation of the data, three predominant themes emerged, these are:

- care work,
- relationships and
- the organisational context.

These themes will be addressed in the following chapters, commencing with the chapter on Nurses' explanations of care work.

This theme of nurses' explanations of care work contained three dominant categories within it. The main coded categories that nurses used to explain their care work were;



- personal values and views
- differing care approaches and
- hindrances.

These will be considered in relation to both the acute, and acute medical care of older people settings as no discernable differences were established through the data.

### **Personal values and views.**

Similarly to the results from other researchers, nurse participants defined their care role by describing it as meeting patients' needs (Astrom et al. 1995, Draper 1996, Greenhalgh et al. 1998, Idvall and Rooke 1998, McQueen 1997, Sourial 1997, Williams 1998).

*N4AMC<sup>3</sup> “making sure the patient is well looked after physically or encouraged to do their own care. Psychosocial care is important too, in terms of getting to know the patient.”*

*N3AMC “I think that all aspects are on a par, if you meet the psychosocial needs but you're missing their physical and emotional then you know they've got these needs still existing so care is looking at the whole package.”*

However, having stated these views, the participants then justified their approach by indicating that an emphasis was mainly on physical need rather than emotional and psychological needs, and explained this as being due to organisational demands such as having all the patients washed and dressed, and getting through the workload.

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<sup>3</sup> As with the patient participants, ward numeric identifiers have been amended to reflect either Acute Care (AC) or Acute Medical Care of older people (AMC) to maintain confidentiality.

*N1AMC “we should be patient orientated, we are patient orientated but we’re still very much task orientated, just getting through all the jobs in the diary”*

*N3AMC “I would like to think we all would see everything (physical, emotional, psychosocial) as important but when you are actually working in the ward area quite a lot of the time the focus is on physical care, especially in the morning, you do sometimes sort of hold back on the psychological”*

The basis of these beliefs, about all aspects of care being important were identified by participants as being encouraged through the educational process that nurses now undertake, although participants also indicated that previous experience could also have an effect on their views of care. Welch (1999) and Sanford (2000) both identify the educational curricular process as having an impact on the development of shared philosophies of care.

*N11AMC “we got taught equally about the kind of psychological aspects of it ...when I started I thought it would be more the technical/medical stuff”*

*N1AMC “I’ve noticed that the more newly trained nurses have a slightly different approach to nursing, we, the old ones, we were all trained the old way and I don’t know if we are all too task orientated, although we... goodness...we care for the patients.”*

*N3AMC “maybe your personal experiences from your training or from where you have worked up until now could impact on how you feel.”*

The issue of getting the work done raised conflict and anxiety within the participants, several of whom identified that if they did not achieve the target of the work being done there was criticism from their colleagues, although this was not necessarily targeted at

individuals and was often from an anonymous source although the participants could make educated guesses as to who was levelling the criticisms.

*N5AC “maybe one of the nurses comes on in the morning and says oh what’s that, where’s the trolley, and maybe you know, you’ve been sitting on a chair so you’ve put the trolley outside.....for convenience really, and they start commenting on things like that right away before they’ve even looked at the patient. It’s just petty.”*

*NIAMC “you make sure the observations are done and all the fluid balance charts are up to date because if you don’t there is always notes in the diary querying why not.”*

*NI3AMC “things are getting missed so we have to sort of go over it and then the other nurses come in on the next shift and say well why is this not done, that’s not done...who was on that day? ... .. so it can cause problems”*

These colleague behaviours were seen as de-motivating and caused tensions within the ward teams, which accords with the results of Astrom et al (1995) who established that nurses needed to feel there was positive co-operation with their colleagues, and that they were valued in order to maintain the caring role.

Maturity was also seen as an aspect that reflected personal views about care, with participants identifying that their length of time in nursing had altered their approach and views. They explain this as being a result of experience, where they do not feel they have to go by the ‘rules’ of care which seem to include getting the job done; and also they are confident and quick in their work of physical care which gives them more time to undertake other activities with patient’s. This fits with Sumner’s (2001) suggestion that the beginner qualified nurse employs strategic action to conform to the norms of

practice, and without question is obedient to the organisation. More mature experienced nurses are able to function autonomously and react appropriately. However, this ability to adapt their approach and react using knowledge and experience as the basis for their behaviour may be what leads the less experienced nurses to criticise their more mature colleagues for not behaving in the way demanded by the organisational norm.

Participants indicated that these rules are not written down but are a part of the culture of the ward, and often are inherent and assumed rather than a specifically detailed policy. These hidden rules cause difficulties for new staff that use a different approach to care, may not have had experience of the care approach in the unit and who, because of organisational issue have not had a proper induction to the unit.

*N12AMC “inexperienced staff, you don’t have the time to orientate them and actually sit down with them... .. go through things properly.”*

*N13AMC “I feel sorry for them because they are just picking things up as they go along.”*

*N9AC(talking about ITU nurses moving to wards) “they don’t have to multi-task, they are doing everything for one patient, they know everything about them but if you ask them to come on to a ward they’ll fall to bits, they just can’t do it.”*

Participants identified that rules to some extent are defined by the charge nurse on the ward, and they are communicated by word of mouth, in communications diaries or sometimes notices pinned on the notice-board.

The more mature and experienced participants feel able to undertake care in a way that they think is appropriate and are not afraid to voice opinions and ideas, or take unilateral

actions when necessary to maintain what they saw as good patient care. This variability of caring, where the caring changes and evolves as a nurse becomes more experienced is seen by Brilowski and Wendler (2005) to typify a caring nurse. Similarly Astrom et al (1995) note that almost all nurses had problems of patient care when they first commenced their jobs but through experience and maturity the nurses had gained strength to continue in nursing. In other work by Dyson (1996) it is suggested that as a nurse becomes more fully experienced their ability to express caring behaviours and values increases, which might explain why the patients in this study identified the more mature nurses as more caring.

The participants' use of the notion of personal values as a means of explaining the care work they do, suggests that participants in this research subscribe to one of the major aspects of the concept of caring, that of it being a moral affect or attitude (Brilowski and Wendler 2005, Morse et al. 1990, White 2002).

*NIAMC "I do think that it is a vocational job. I think it is something you have to have inside you to want to do. The student nurses all seem to have the right attitude to patient care they really are very caring people, and normally the others have dropped out by the end of Year 1 having realised it (nursing) wasn't for them"*

*N5AC "I think its part of, you know, your basic caring nature, but some people need to be taught as well. Some people might have a basic caring nature but if they have seen nurses behaving in a poor way they might just think that's acceptable."*

However, a major issue that arose from the use of personal views and values was the apparent lack in any of the wards of a common shared philosophy of care. As identified in the literature review this was an area that was to be established through this research.

Although nurses individually have a clear idea of the integrated nature of care; and regardless of their maturity in their careers, can define what caring means to them (Kapborg and Bertero 2003, Skott and Eriksonn 2005, Wilkin and Slevin 2004) they all work to their own philosophies of care rather than having a shared philosophy.

Why this might have occurred, along with the lack of a specified shared philosophy for the ward is an interesting issue. It could be suggested that this has arisen from the organisation assuming that all nurses inherently subscribe to a shared philosophy of care by the very nature of them being 'nurses' and having the same or similar educational experiences that are defined by the professional body, the Nursing and Midwifery Council. This assumption that nurses are a homogenous group and therefore interchangeable, with no effect on the patient care is identified by Salvage (1990), Morse (1991) and de Raeve (2002). If the organisation is working with this assumption they may feel it adequate to have a high level organisational nursing philosophy as identified by Tuck et al (2000) with the belief that all nurses will subscribe to that philosophy, although it does not necessarily reflect the nature of the care as it is delivered at ward level. This notion that nurses form a homogenous group is also found in the patients' responses.

Other research by Wilkes and Wallis (1998) and Patistea (1999) highlights that differences in themes of caring exist between different educational institutions, and thus the curriculum, which can influence the philosophy of care adopted by the nurse. Therefore, as the participants in this study suggest, without a shared philosophy of care within a ward difficulties will arise regarding the nature and practice of care, as each individual imposes their own perspective on the patient's care.

## **Summary**

Nurses' justified their approach of getting the job or work done although this often conflicted with their own personal values and beliefs regarding the care of patients. This conflict caused them anxiety and stress, however, the perception of criticism from their nurse colleagues should the work not be done prevented them from behaving in a way that was congruent with their values.

The level of maturity as a nurse clearly affected their ability to function autonomously. With those of a greater length of experience in the older people care sector being able to circumvent the 'rules' of care and adapt their care approach in relation to the situation they found themselves in rather than slavishly following the 'hidden' rules of the ward. The 'hidden' rules form part of the ward culture and are often unspoken and inherent in the expectations of the nurses, they do not exist as specified policy. This caused significant problems for new in post or newly qualified staff. Compounding these difficulties was the lack of a shared philosophy of care, with the organisation assuming that all nurses subscribed to the same philosophy of care by dint of being qualified nurses. This leads to differing care approaches being used in one ward setting.

## **Differing Care Approaches.**

The category of differing care approaches emerged strongly from the participants in the study.

*N11AMC "I personally think... you get the patients' needs first and then you can make beds but I have noticed some people do the beds, you have to make the beds even though*

*there are still patients waiting to be washed. Obviously I realise you have a routine on the ward but then I think that is where people work differently.”*

*N10AC “there are just people that you find it harder to work with. Maybe your philosophies are different as to what you are there.....aiming to do.”*

*N7AC”I think about the niceties of the job but a lot of people are very task orientated, they don’t give patients choices.”*

This difference in care approaches could relate back to the maturity of the nurse, some who have been well established into a ward tradition and feel comfortable with doing things the way they have always been done and others who are new and inexperienced who just tick off the jobs as a means of coping (Astrom et al. 1995). However, maturity in the role of a nurse does not explain all differences in care approaches.

One respondent (N14AC) described, at length, a care situation where the woman was at the end stage of life and she felt they should have been taking their time in getting her comfortable; she was drifting in and out of consciousness, and making her aware that they were there caring for her. However, the nurse working with the respondent was very focussed on just getting the task done whilst the woman’s relatives were out of the room taking a break. The woman died during the care, and the final straw for the respondent was the way her colleague nurse then told the relatives.

*N14AC “the daughter then came in while we were finishing our task and the other nurse shouted over to the other side of the bed – ‘I’m really sorry she has just passed’, and I have never been so astounded in my life. I just thought that it was not how an experienced nurse should have...the lady ...the daughter crumpled at the door”.*



This example indicates that the lack of a shared philosophy of care within a ward can lead to confusion, tension and distress for the nurses and also potentially for patients and their relatives. It seems to exacerbate the tension between nurses in terms of the role and behaviour of the nurse and also in relation to the care given to patients. McCance et al (1999) suggest that nurses need to understand the underpinning theory of caring to be able to use it. This may have been lost from nursing curricula due to the long and ongoing theoretical debate regarding the concept of caring, along with an increasing demand for more techno-rational knowledge in nursing. The lack of understanding of the underpinning theoretical framework of caring may explain the differences in philosophy used by the participants.

Several participants identified the lack of a shared philosophy as a cause of poor patient care.

*N7AC “well there’s things like- you ask a junior nurse for something to be done, it may be done eventually after you remind them four or five times, but an example is yesterday a nurse took a patient into the shower and then after they had had their break they remembered that the patient was still in there an hour later, and that would never have happened, you would never dream of going for your break rather than finish dealing with a patient.”*

*N11AMC “there was a lady, who in the morning was frequently incontinent and breakfasts were starting in 5 minutes and were short staffed, and I wanted to clean her up first, but I could tell the other nurse was getting annoyed because she wanted to leave her and do her after. I thought it is like negligence to leave her like that, I don’t want to...I know our breakfasts might then be slower but they are still going to be done.”*

These differences in care approaches may be the result of each individual nurse's construct of the reality of their caring situation. Ellis (1999) and Skott and Eriksson (2005) suggest that every act of care and personal experience of being a carer involves the unique person; as the nurse bases their care on their own experiences, and attempts to make sense of their reality. The nurse discussed in the second example above, may feel her reality is to make sure the tasks and jobs are done on time in order to meet organisational demands, rather than offering person centred care, which would seem to be the participants approach. However, Wiggins (1997) and Philpin (2002) both identify that routine behaviour in nursing reduces stress and anxiety for the nurse, although routinised work leads to the nurse not feeling valued (Gifford 2002, Turkel and Ray 2004). It maybe that by using routinised work and getting the job done, the nurses prevent themselves from feeling stressed.

This lack of a shared philosophy of care resulted in the participants experiencing tension and frustration in their work through the lack of ability to deliver what they perceived as quality care, and also perceived criticism from their peers regarding their personal performance. As Williams (1998) noted in her study, this contributed to feelings of dissatisfaction and frustration with their work which led to stress. To protect themselves nurses were indifferent in their attitudes and withdrew from patient involvement. Not surprisingly, the more stressed and frustrated the nurses felt the less able they appeared to be to deliver quality care. Participants reflected these attributes regarding performance and used organisational aspects of the care environment to explain their poor performances.

*N14AC “I think a lot of the frustration of bad practice has come down because of time management and time constraints, I am thinking about people going home without drugs, or blood results not being recorded, it was because you have got so many things to think about”*

*N7AC “it’s like the pre-med is written up for 8 o’clock so that’s when I have to give it, and now you (the patient) can go for your shower. That’s not going to work because the pre-med makes them sleepy but they (the nurses) don’t see past the time on the sheet and when the patient has to get the pre-med in order to go to theatre at the right time.”*

Similarly the participants appear not to recognise the individualised care element in times of low staffing, thus reducing patient choice, involvement in care and independence.

*N12AMC “You try to get them independent, but... .. it’s the time and safety as well because if you are with a patient waiting for them to do something and you have got two people buzzing for the toilet, its easier to help them (the patient), do it for them so they are safe and then go on to the next person, because you are limited with your staff.”*

This again gives rise to internal conflict in the nurse between knowing what she should do, and doing what she can do within the constraints of the organisational restrictions.

## **Summary**

As in the personal values and beliefs, maturity of the nurse seems to significantly affect the differing approaches used in delivering care. This can be ascribed to a different educational background or to the lack of an underpinning theoretical framework of caring which seems to have been lost in the drive to meet the increasing demand for

nurses with techno-rational knowledge. This lack of underpinning framework explains the different philosophies being applied in caring and was also identified as a cause of poor patient care through routinised behaviours of getting the job done.

However, routinised behaviours reduce levels of stress and anxiety in the nurse as they feel they are meeting the organisational demands but the behaviours, because they conflict with the nurse's care beliefs can lead to a loss of feeling valued. The nurse experiences tension and frustration at the lack of ability to deliver quality care and promotes the development of a vicious circle whereby the nurse withdraws from patient involvement and becomes indifferent in their approach. Evidence of this behaviour was identified in both the patient and nurse data. The nurses' blamed this behaviour on the organisation in relation to time constraints and staffing levels, often using safety of other patients as a justification for routinised behaviour. This affects patient management and is seen to hinder the ability to do the care work the way the respondent feels it should be done.

### **Hindrances to care work.**

Participants identified two major elements that hindered their care work, those of resources and teamwork. These results reflect those of others in suggesting that obstacles to good quality care seem to be beyond the level of the nurse providing the care, and to some extent are organisational obstacles (Astrom et al. 1995, Idvall and Rooke 1998, Williams 1998).

The resource hindrances to care were interlinked in terms of the effect they had on the participants' experiences of caring and were divided, by participants, into comments

regarding equipment availability, staffing also referring to 'the right sort of nurse', and effects of time constraints.

Many participants were critical of organisational systems which created unnecessary work and thus reduced the time available for patient care. Examples mainly related to physical resources and equipment being unavailable or not readily to hand, therefore, the participants either had to spend time searching it out or improvise in order to provide the appropriate care for the patient.

*N11AMC "you know if someone needs a slide sheet and its not there, you think for god's sake and then like... you just wish it was there so you could just do it properly. I think if we had everything we needed you wouldn't be so stressed out all the time."*

*N9AC "a prime example, we didn't have any air inlets, so the other nurse was 'oh we can't give this drug we'll have to omit it.' I was like, have you been downstairs (to other ward) if you can't leave the ward phone down and they can run up with it, but they didn't have one nor did Ward...so we ended up using a sterile needle, which has the same effect but the other nurse wasn't happy ... 'oh I don't know if we're allowed to do that' but I said how else are you going to get it in."*

*N10AC "we are always running out of pads and things like that.....but it's not the nurses that work on the ward on a daily basis that do the ordering ...they're not involved in the ward...which I find very frustrating. We always have to go to other wards and borrow and they don't like that."*

*N12AMC "It can be as simple as running out of pads and pants, and sheets in the morning, you know and having to phone the resource nurse up... that's time again...and you are always having to run along to the laundry...so the patient that's needing a bed-bath...they are having to wait."*

This need to go off the wards to borrow or find equipment to enable the participants to deliver at least adequate care for the patients is remarkably time consuming and reduces time available for direct patient care. It appeared that some nurses could behave in creative ways to improvise adequate care resources, thus reflecting the notion of having the 'right sort of nurse' who could do the job without requiring assistance. This to some extent may reflect the art of nursing as identified by Idvall and Rooke (1998) and Greenhalgh et al (1998). Participants were able to identify why these shortages occurred and what could be done to prevent it. The current situation was that the stores department or a specifically designated nurse (usually a specialist charge nurse or nurse practitioner) undertook the ordering of stock. The assumption from the organisational management, according to the participants, was that this would free them, the more junior nurses, up to do actual patient care. However, because the people ordering stock had no real experience or knowledge of the ward needs, stock ordered was either short or irrelevant to the patients' needs resulting in wastage and expense.

*N9AC "I mean there is no need for stores doing it, because they don't work in the ward, they were ordering absolutely ridiculous things that we don't use. I mean this is a male ward and they were ordering Tena Lady Incontinence pads ...boxes of them...and it's a waste of money"*

Another issue highlighted by participants that affected time for patient care was the taking on of new extended roles, as well as organisational roles, particularly at weekends.

This resulted in nurses who were ostensibly part of the ward team being away from the patient care areas, and therefore, not contributing to the care activities for their own patient groups.

*N5AC “as an F grade you are expected to take the bleep, and you know you might only be on duty with one other qualified nurse, so you are called away a lot and you are continually asking the other nurse to do something for your patients or whatever. That makes it a bit more difficult, really, time constraints”*

*N3AMC “senior nurses are having to carry the bleep now and that takes up quite a bit of time, and we’re not getting in anyone extra when you are doing it, and its only checking staffing but if you’ve got a problem in one ward and you are trying to find staff for them it can take up time which then takes you away from the patient area.”*

These organisational aspects would appear to influence the participants’ perceptions of having adequate staffing on the wards. Many participants indicated that the care and working environment would be better if they had more staff to do the work. They also alluded to the notion of the ‘right sort of nurse’ for the work, and how this would improve teamwork. However, on discussing staffing levels in the wards they were at establishment numbers, so there is a dichotomy here regarding what the organisation feels is appropriate resourcing in terms of staffing and what nurses perceive as being adequate. This perception could well be affected by the nurse’s values and beliefs but also by how the organisation values them. This will be addressed later in Chapter 9: Nurses and the Organisational Context of Care.

*N8AMC “at the moment we have 4 trained staff on in the morning and 2 untrained, and we have 24 patients. We recently had our staffing of untrained cut because we were over our establishment”*

*N13AMC “well for 30 patients its eight on in the morning and the afternoon it’s six and the evening it’s four.....but sometimes there’s only two qualified staff and agency.”*

Similarly participants who were adequately staffed felt their work was affected by the moving of staff to other areas that were short staffed through staff absence.

*N9AC “ when we are well staffed the nurses get taken and put elsewhere in the hospital and that really hacks everybody off..... it just puts an air of gloom about the place...why should we be penalised because someone else is light staffed.*

The issue of the ‘right sort of staff’ also appears to affect the participants’ perceptions of adequate staffing and teamwork. What constitutes the ‘right sort of nurse’ was not often overtly defined by participants but appeared to relate to the nurse’s approach to work and attitude and again appears to reflect the nurse’s ability in the art of nursing rather than their technical skills (Greenhalgh et al. 1998, Idvall and Rooke 1998)

*N5AC “...not necessarily more staff, because I think sometimes you’ve got the staff numbers but the care is still not up to scratch. So really I think it depends who’s there...”*

*N12AMC “it just depends on the person, I think before you are a nurse you are a human being and it depends on how you look at things, maybe to them it’s the patient or just the way they look at the kind of care.”*



*NIAMC “as long as you’ve got the right sort of nurse it can only benefit patient care”.*

This latter respondent elaborated her view of the right sort of nurse by explaining that this would be someone who empathised with the patients, and were kind and caring to them in their treatment and behaviours, whereas the others tend to be very short and sharp in their dealings with patients and see it as just a job and do not really care about the patient. She explained that this latter sort of person probably got employed because of staff shortages rather than because they were the right sort of person. This issue of being human and behaving in certain way links to identification of caring as a human trait and a vocation (Allmark 1998, McCance et al. 1999, Morse et al. 1990, Tarlier 2004, White 2002).

Many participants identified that certain nurses were more suited to certain types of nursing environment, and that this might affect whether they were the ‘right sort of nurse’ or not, as if they were not comfortable and happy in their working environment this would affect the care they provided to patients. However, this was not reflected in the results of research by Idvall and Rooke (1998) and McQueen (2000) looking at attributes of nurses in various care settings.

*N13AMC “it takes all sorts in nursing, it takes all types of people to do different things, and they couldn’t do my job”*

*N7AC “I think people are suited to certain jobs, I am not comfortable as a ward nurse I will ultimately end up back in critical care because that’s what I am happy doing.”*

*N11AMC “there’s certain things that attract people to jobs... a lot of my friends work in HDU and wouldn’t consider working with older people because they see it as very*

*stressful and demanding physically and mentally and with no highly skilled technical care, as they see it.....but I couldn't take HDU. I think it's just personality and there is just something that attracts you to it, what you prefer."*

These conflicting personalities and approaches also seemed to affect the respondent's abilities to work as team members, with teams working well when they all enjoyed the work and had a similar philosophical approach to care. It may also reflect the experience levels of the nurses in the team, with Brilowski and Wendler (2005) suggesting that variability is an aspect of care that is learned through experience, and therefore, the nature of the caring approach will change or evolve as a nurse becomes more proficient in their practice.

*N10AC "It's not everybody that thinks like that and sometimes it will depend on who you are working with what kind of day you will have, the environment amongst the staff can change, and there are just people that you find it harder to work with.*

The other issue that affected teamwork and was a hindrance to care was the issue of lack of team communication. Team communication and handover approaches were seen by participants to be lacking and this had an impact on the care work experience. Two significant aspects that affect communication and handover were identified as staff rostering and shift work. Similarly to Morse et al (1991) participants felt that 12 hour shift patterns had good and bad aspects to their communication. The lack of handover time meant many wards had moved to tape recorded handover reports, that the nurses listened to when they came on duty rather than getting a verbal report from the person in charge of the ward, this approach now appearing to be commonplace in hospitals

(Adams et al. 1998, Bleich 2002). In some wards staff commenced work at different times, for example, 7am, 7.30am and 8am, and therefore a taped report was seen as the most efficient way to communicate about patients. Similarly the night shift could complete the 8 am drug round without rushing to give the handover. However, these taped reports were also seen as a missed opportunity for specific communication and teaching. The technology also caused problems with poor quality of recording thus there was potential for errors in communication with no recourse to clarification.

*N15AMC “it’s quite time-saving, but then there’s other negative thing as well. Sometimes they are hard to make out what someone is saying or the tape runs a bit slow or a bit fast.”*

It is interesting that this form of handover is seen as time saving because a nurse, or several nurses will still have to record the report and that will take time. Bleich (2002) argues that the change in ways of working in nursing has not been matched by changes in organisational activities such as handovers and report time, and this in itself has led to inefficiencies in the system of working.

With no formalised verbal handover times the opportunity for discussion of challenging, critical incidents or for staff to make suggestions regarding processes and to share knowledge was lost. This might explain the lack of a shared philosophy of care being available as there is no recognised mechanism for developing team cohesion and working patterns which Latimer (1998) and Payne et al. (2000) both argue is necessary for group cohesiveness and complex functioning. When asked about formal systems of staff support and clinical discussion participants all confirmed that these did not happen.

*N3AMC “I suppose at the end of the shift some of us might chat about how we could maybe have done it better; or about how we were feeling at the end of it and I think that would be helpful because some of us were sitting down and writing things together. Saying, you know, I didn’t get that done and we didn’t do this and couldn’t manage that and I suppose in that way its very informal.”*

*N14AC “you don’t get the chance to talk, and I know from experience it helps to be able to reflect and talk through something that you were worried about. I suppose we used to do it at report.”*

The taped handover may also lead to errors and mismanagement of patients. Several participants referred to incidents when patients’ care had been neglected for an unacceptable period of time because the handover had not highlighted the need for care.

*N7AC “the patient wasn’t handed over, there was drugs lying on top of the locker.....they had had no fluids for several hours, their urine output was 5-10mls an hour. They had a PCA (patient controlled analgesia) and a call bell that they couldn’t reach and the brakes hadn’t been put on, on the bed.”*

This use of taped handovers seemed to allow nurses to get off duty at the correct time, which was valued, however, as one respondent pointed out when you were on a core shift (7 hours) you didn’t mind being half an hour off late occasionally but on a 12 hour shift you certainly resented it.

The 12 hour shift pattern also caused difficulties for nurses in terms of continuity of knowledge regarding patients and was seen to hinder their care work, again reflecting work by Bleich (2002).

*N4AMC* “you may not have been on the ward for four days and come on and be expected to be in charge on your first day and do a ward round and you don’t really know the patients and situations”

*N10AC* “when you are on for three days in a row its fine, you come in and by the third day you know what’s happening with everybody but then you can be off for four days and when you come back there are new patients in and you have to catch up on what’s gone on.”

Participants indicated that some areas had instituted a weekly ward meeting for staff as a means of remedying this lack of communication, and one could argue going back to a variation of the handover. These were a very recent innovation and the participants felt that they were used mainly for communication of organisational issues and for discussion of situations that resulted in incident reports being filed. The reality of this was also that nurses would have to use up more time in their shift to attend this meeting rather than to undertake patient care.

## **Summary**

Two main hindrances were identified, resources and teamwork. Resource issues related to the view from the participants that the organisation, through the management practices used, created unnecessary work. This mainly related to the lack of required resources being at hand and thus having to be sought out. The impact of this unnecessary work was reduced by the creative improvisation used by some nurses to meet the patient’s needs. Issues of staffing and extended roles also acted as a hindrance to care work.

Teamwork was affected by issues of the ‘right sort of nurse’ for the job. The right sort of nurse appeared to be one who had a similar approach and attitude to the work required,

when this did not happen conflict occurred within the team. Team communication also proved a hindrance, with organisational practices such as taped handovers and 12 hour shift patterns being implicated.

## **Conclusion**

The results in this chapter indicate that nurse participants are aware of their own values and beliefs regarding caring, and they also identify conflict that arises when there are discrepancies between individual nurse's beliefs. There appears to be a lack of a common shared philosophy of care in the care settings, with nurses basing their care approach on their own beliefs and values. This potentially is due to an organisational belief of nurses being a homogenous group and therefore individuals are interchangeable. Furthermore, differences in care approaches arise in relation to the maturity, experience and attitude of the nurse, leading to the notion of the 'right sort of nurse'

Tension and frustration in their work, were identified as issues by the nurses, which led to stress and an inability to deliver quality care. Participants were able to identify hindrances to care work that were caused by the organisation, and these tended to be related to resources and issues of teamwork and communication.

Having gained an understanding of the nurses' explanations of the care work they do, the effect this has on their relationship with the patient requires to be addressed.

## CHAPTER 9

### NURSE RELATIONSHIPS IN THE CARE SITUATION

To assist in understanding how nurses define themselves in relation to caring for older people it is essential to explore the nature of the relationships the nurse has with patients in the care setting. There is also a need to ascertain the ways these relationships are achieved, and how they are affected by the care situation. The literature review revealed an on-going research base related to the nurse-patient relationship but the work was unrelated to age groups of patients.

The theme of relationship was one to emerge from the data, with coded categories relating to nurse influences, relatives, negotiation of care, and care planning approaches.

#### **Nurse influences on relationships.**

The majority of nurse participants indicated that they felt they had a strong relationship with the patients they were caring for. However, the development and strength of this relationship was dependent on length of stay of the patient.

*N11AMC “so obviously especially if a patient has been here a long time you do form relationships...you can’t really not.”*

*N10AC “most of our patients are in for at least a few days so if you are on those days you will get to know them quite well.*

*N15AC “if you do only have a couple of days to get to know them sometimes its just very much nurse patient functional kind of thing”*

The establishment and maintenance of the relationship was seen by the participants to be the nurses' responsibility and the way the rapport developed was mediated through the physical nursing care delivered by the participant. This approach reflects that identified by Morse (1991) and Haggman-Laitila and Astedt-Kurki (1994) as a therapeutic relationship whereby the relationships are generally short lived with care given quickly and effectively. The nurse views the patient first in their role as patient and secondly as an individual with an external life. Similarly, Ramos (1992) identified the responsibility for maintaining the bond through regulating disclosure and controlling the direction as being the nurse's role. The use of the physical care situation was seen, by participants, as a legitimate way of gaining access to the person rather than the patient, and it was argued that it also was a means of reducing the patient's anxiety and stress relating to their care.

*N3AMC "you just start talking to them, its maybe doing a drug round 'have you got any pain' having a chat. Or when I'm washing a patient I think that's a really good time, because that's so personal for them, having someone come in and help when they've had years of independence. You know I try to break the ice there and make it better for them"*

*N14AC "I think it very much depends on how sick or debilitated they are. I think the relationship changes with somebody depending on how much nursing intervention you are giving them"*

This type of nurse-patient relationship accords well with that defined by Morse (1991) as a therapeutic relationship, where patient needs are not great and care is given quickly and effectively in a relationship of relatively short duration. Patients expect to be treated



as patients and have a reasonable psychosocial support system external to their hospital stay.

However, within the relationship nurse participants were also able to identify and respond to cues from the patients as a means of deciding whether the patient wanted to interact with them or not. How participants actually did this was not clear and they did not articulate how they knew if the patient was interested in an interaction with them or not.

*NIAMC “I think it’s an unconscious thing I think, depending on your experiences as well and your life outside”*

*NI5AC “I think we should take the lead from them as to how far they want to go with it. Some patients are quite chatty and a laugh and other ones are introverted and would rather do their crossword.*

*NI4AC “I think it’s a two-way street as there is some people because of different personalities that don’t want to get friendly and don’t want to tell you things and its about assessing the personality of the patient.”*

Sometimes the cues from patients were read wrongly and this led to difficult situations. One participant talks extensively about a situation with a patient where a senior colleague misread the cues from the patient and the situation degenerated into violence and upset, with the outcome being self-discharge by the patient.

Some participants talked about patients with whom they ‘clicked’ or connected with, in terms of the relationship, and felt that was to do with being human, and related to everyday relationships as well as those with patients. This notion of a ‘click’ was identified by Morse (1991) where the nurse responds to the patient as a person, decides

whether to facilitate a connected relationship, perseveres in her attempts regardless of the patient's response and gets to know the family.

*NI3AMC "It varies from patient to patient as well. You know, you are only human, there are certain people that you do click with".*

*NIAMC "There are patients that you connect with, but even the ones you don't maybe connect with, its good to have that challenge".*

What participants did not comment on was this issue of the patients' responses to their overtures, which Morse (1991), Ramos (1992), Haggman-Laitila and Astedt-Kurki (1994) and Williams (2001a) all suggest is vital in the development of the nurse-patient relationship.

To some extent the nature of these relationships had an effect on the care provided for the patients, with the more interactive patients potentially receiving more attention.

*NIAMC "There are patients that are more introverted and these are the patients that tend to get forgotten"*

Sometimes participants worked hard to establish a relationship with a 'difficult' patient. This was seen as someone who had a difficult manner or responded in challenging ways to the care offered. Whether the participants worked at these relationships because they were seen as a challenge to their role and image of themselves as a nurse and thus they should have a relationship as suggested by Draper (1996). Or whether for the sake of the patient's on-going health and care, the participants deemed it necessary to have a

relationship to allow them to negotiate and plan care with the patient, is unclear; although Haggman-Laitila and Astedt-Kurki (1994) note that nurses expected to be able to deliver holistic, patient-centred care where the nurse-patient relationship was considered to be essential.

*N3AMC” Its probably you that has to work at gaining a relationship because at the end of the day you have at some point know something about them in order to care for them.*

More experienced and mature participants identified when patients responded better to certain staff and took steps to facilitate the patient being cared for by that person. Although this was seen as difficult due to the care approaches adopted by the organisation in terms of 12 hour shifts and staff allocation and, in particular, the named nurse initiative.

A further aspect of the patient relationship was the involvement of the relatives, an issue also addressed by Morse (1991). Participants explained that their relationship with patients was often affected by the influence of relatives and this also impinged on the way they felt they could care for the patient.

*N7AC “relatives have a huge impact on our work. If you have a lovely patient but difficult relatives the nurses can be less inclined to look after that patient”*

*N5AC “You get relatives that are kind of in your face all the time.....you know they want to know everything and you get others who are quite oblivious, you’ve actually got to make a point of telling them how the patient is progressing”*

Making an effort to develop a relationship with the relatives was seen as helpful by some participants, although the organisation of shift patterns again made it difficult to maintain this as often the nurse would be off duty when the relatives were in, or lacked time to establish a relationship.

*N8AMC "I don't think there is really time for a relationship, especially with everyone and their families.*

*NIAMC "If the relative is communicating to you, that's something, because relatives' expectations are quite difficult sometimes."*

Participants identified that meeting and communicating with relatives could be quite an issue for the nurses which reflects results from Astrom et al (1995). This was explained by participants as being due to the relatives' expectations whereby relatives often expected the nurses to do more for the patient than was necessary, and gave implied criticism of the care. This potentially resulted in nurses being over protective and failing to offer the patient the chance to be independent due to relative's anxieties and expectations that everything should be done for the patient. This behaviour in itself affects the nurse-patient relationship and as Ramos (1992) notes the relationship did not develop further if the nurse did not negotiate decisions with the patient or the patient lacked assertiveness.

*N7AC "and you look at your patient from head to toe and you think OK everything's in order, they look tidy and the bed is clean and crisp. And then the relatives are 'oh you haven't read him his cards', and' oh, you can't do that for yourself get the nurses'."*

Participants felt that sometimes the relatives' approach had been influenced by their previous experiences of the health care sector and that they came in with a negative viewpoint of the care the patient was going to receive. To alter this perspective, participants tried to offer care that was of a higher quality than previously thus convincing the relatives of their care for the patient.

*N8AMC "You also find that maybe the family aren't as happy as they should when they get here, and then the family's aspects, their opinions of the nurses will kind of increase while they are here, because they have seen their basic care needs being cared for before anything else."*

To prevent the need to justify the care they give to the relatives, nurses may not offer choices or encourage independence as a means of protecting themselves from criticism. They also had to manage or control their inner feelings when facing rude or aggressive relatives. This protective behaviour may extend to the skill of not making eye-contact with people in the corridor or at the nurses' station, as observed in the field notes, as a means of ignoring someone who might ask awkward, challenging questions or confront the nurse. This behaviour is potentially more prevalent in the junior, less experienced nurses, and may be a means of safe guarding their fragile self-identity of a nurse doing a good job (Irurita and Williams 2001). It is also possible that they know they haven't achieved all they could in terms of care and, therefore, do not want to be exposed to external criticism as well as their own internal criticism. This behaviour was identified by Draper (1996) in terms of distancing oneself from a behaviour that conflicts with an espoused belief. Similarly, McQueen (1997) suggests the organisational structure should

offer nurses some protection against physical and psychological exhaustion if effective relationships are to be maintained by the nurses. Interestingly this point was raised by one respondent who felt that to have a counsellor available for staff would assist the staff to maintain a positive and helpful outlook on their care work.

*NIAMC “I think it would be a really good idea if there could be some sort of system in place where nurses who are particularly stressed could go and talk to someone who would listen to them, independent of the hospital.”*

### **Summary**

The participants indicated that they had a strong relationship with the patients but the development and strength of the relationship was directly related to length of patient stay. The participants were clear that they saw it as their role to establish and maintain the relationship and this was often done during times of physical caring, where they tried to find out about the person not the patient. Response to cues was seen as a way of identifying whether a patient was interested in participating in the interactions or not. Several participants identified the issue of people they related better to, or clicked with, through commonality of background or interests. However, the ability of the patient to participate in interaction, or respond to a relationship affected the amount of attention they received, thus introverted or withdrawn patients potentially received less attention. Difficult patients were seen as a challenge to some nurses who deliberately attempted to get to know them, possibly because not to have a relationship with the patient was a threat to their role as a nurse.

Relative involvement was also seen as important but difficult to achieve as it was affected by shift patterns. Relatives were also potentially a problem in developing a relationship with the patient if they complained about the care, and were often identified by the nurses as having preconceived ideas from previous experiences of poor care. Nurses did not always offer choices or negotiate care as a means of protecting themselves from criticism.

### **Negotiation and choices**

Participants indicated that they needed to have a relationship with the patients in order to allow them to plan and negotiate care. Indeed Tarlier (2004) suggests that collaboration and negotiation are fundamental to a responsive nurse - patient relationship. However, this ability to negotiate and plan care required time which many participants felt they were lacking.

*N5AC “When I first came here it was the folders (care plans) at the foot of the bed but they were not updated properly and gradually over time people have stopped using them.*

*N3AMC “we are actually **meant** to discuss care plans with patients that come in, and some of them I will say to them... .. I will write these care plans for you so that they know what the care is that you are giving.*

*N15AC “There is not really the time to sit down and spend a lot of time care planning for activity and daily work, there’s not much chance for you to sort of chat with the patient about what they would like to do.*

Thus the participants acknowledged that that care was discussed with the patients but not really negotiated with them; therefore, the power in terms of the care situation remained firmly with the nurses. For example one participant (N3AMC) when talking about negotiating with a patient regarding the refusal to take a drug says:

*N3AMC “usually if it is about drugs then I will try and persuade them and explain to them what the drugs are doing for them so they have a better understanding why its important to take the drug but if they absolutely refuse well, you can’t force them down their neck so you go to the doctor and ask them to talk to the patient about it”.*

In this situation the nurse was not prepared to accept the patient’s decision and brought in the higher authority to achieve her goal of the patient taking her drugs.

*N7AC “a lot of nurses don’t give the patients the choice, they are very task orientated and they say people have to be washed every day”.*

As Ramos (1992) indicates a protective level of relationship was controlled by the nurses, and was described as a unilateral connection, which reflects Morse’s (1991) results. Although the nurses in Ramos’s (1992) work claim to understand the patient’s situation, the behaviours they adopted were based on their own values, beliefs and knowledge, and the assumption was made that the patient’s wishes corresponded to those of the nurses. This relationship did not develop further if the nurse did not negotiate decisions with the patient or the patient lacked assertiveness.



Several participants felt that the care planning activities, used as a means of establishing a relationship, were to some extent used just to pay lip service to the organisational demand for patient centred care and use of care plans; and this was why they were not used in terms of the care delivered to the patients.

However, participants did feel that patients were given choice within the constraints of the organisation. These choices were very much seen as the minor aspects of choice such as when to have a bath or shower, what clothes to wear, what time to get out of bed and similar. One participant identified that although patients should have choice in their care it was important that the wards had routines otherwise it would not run so well.

*N11AMC “Like obviously there is a routine in the ward and like, even though I am saying they need choices obviously we still do need a routine otherwise a ward wouldn’t run.*

However, the element of choice seemed to be mediated by some nurses because of the nature of the patient’s perceived dependence. To some extent this was age related and participants appeared to be aware of the dichotomy of this activity, where they were trying to promote choice and independence but in fact, restricted patient choice by their behaviours.

*N7AC “I think people look after the older patients a bit more to be honest, although they are not as respectful, its easy to get into the way of going ‘oh Tony’ automatically going for their first name although the patient might not like that.*

*N10AC “generally the younger ones will say I want to go for a shower, and if they can they will be allowed to, but you don’t necessarily let a 75 year old man go and do that. But there is no actual need for that, there’s just, I don’t know, people are a bit more protective of them almost.”*

This potential overprotection of older people, restricting their choice and freedom, may stem from concerns or fears that an incident may occur and the nurse will be held responsible and accountable (which organisationally may be the case) or because the assumption is made that older people per se are not capable of making choices/decisions because they are old and therefore, by default less mentally competent.

One participant illustrates this well using a description of a conversation she had with her 70 year old father.

*N9AC “he was saying that when you are young and have got a contrary opinion you are seen as a forward thinking person with views and ideas, but as you mature and are getting towards your twilight and behave in that way you are seen as becoming difficult.”*

Again, although participants pay lip service to the notion of patient negotiation and choice, they spend a lot of time coercing and persuading patients to behave in an appropriate manner. If patients do not wish to take their drugs, or go into residential care or object to the nurse’s decisions the participants react in a variety of ways.

Several participants indicated they would try quite hard to convince the patient to do what was required of them; as long as it was something the participant thought was important. This reflects the issue of a control impasse identified by Ramos (1992)

whereby the patient and nurse relationship breaks down due to differing beliefs and values. Participants seemed to find it difficult to accept that older people might refuse or disagree with the care being offered and although in effect the decision/choice is seen to be made by the patient the participants emphasised the efforts they made to convince the patient to change their minds. Haggman-Laitila and Astedt-Kurki (1994) suggest that although the nurses indicated that they dealt with patients in an holistic and patient-centred way they in fact treated all patients in the same impersonal way using a 'pattern' of approach for the interaction.

*N9AC "I mean if something needs to be done and they don't want it...like medication or antibiotics then I will put my case across and say look you really need this because.....if they then refuse its entirely up to them, they have been informed.*

*N15AC "yes certainly not wanting to do something and I have seen people being cajoled into doing something they maybe would have preferred not to."*

In some situations, the participants would resort to requesting the doctors to come and speak to the patients as a means of coercing them to accept the treatment. This might be because of a variety of reasons, with participants indicating it may be that the medical staff are particularly keen that the treatment should happen and therefore, the implication is that the nurse should make the effort to convince the patient and if this does not happen the medical staff have the final say. This resorting to a higher authority was explained by the participants to be because the patients saw the medical staff as the ultimate decision maker, and for this generational group of patients, it was that the 'doctor knows best'.

However, it would also appear from participants that a patient who does not wish to have treatment causes them a lot of extra administrative work, which includes indicating that the issue has been referred to someone higher organisationally, and that this might explain the level of coercing and cajoling that takes place.

The fact that the patient expresses a contradictory view may be a problem for some nurses as it challenges their position as a professional who 'knows best' regarding the care being offered. Nurses may feel threatened in their role by someone who wants to be involved in their decision-making because it negates the nurses 'professional self' in some way (Draper 1996, Ramos 1992). Paradoxically, by bringing the doctors into the persuasion session the nurse in effect is negating her own autonomy and responsibility as a nurse. It could be, though, that the nurse uses the doctor as back up or support as a means of confirming that the nurse was right, or the nurse felt the need for a higher authority decision because they themselves do not want to take responsibility for accepting that patient's decision.

In order for this coercive behaviour to succeed the participants recognised that they would require a reasonable relationship with the patient. However, some participants explained that not all patients wished to be involved in choice and decision-making and this at times presented them with a quandary as they felt the patient should have control over that aspect of their care. This perceived lack of desire to make decisions was thought to stem from the age and expectation of the patient, with participants assigning this lack of enthusiasm for choice and decision making to the philosophy the patients held about hospital care and the esteem they held care professionals, such as doctors and nurses, in.

*N3AMC “No some of them are... ‘I like you to choose nurse I’d rather you did it for me’ but in some ways I feel that you’re taking away a bit of their control which is important in the hospital environment, it is really important to give control to the individual.”*

The participants assigned to patients the view that by coming into hospital they become disempowered and feel that they shouldn’t do things for themselves.

*N7AC “its just I think it disempowers them almost when they come into hospital so they feel they can’t do anything for themselves and if someone offers to do something sometimes it might be the case that they don’t want to offend you.”*

*N10AC “ you get the ones that want you to do everything for them.....its almost a sick rule thing.....because they are in hospital that is what happens ...like they will ask you to pass them something they are perfectly capable of reaching for themselves.”*

Participants identified that if patients did not respond to the coercion, the nature of their relationship changed with that patient. However, this explanation was always given in relation to other nurses not themselves, possibly as a means of protecting themselves from the fact that they felt they should not be affected by this behaviour. Participants quite clearly identified that nurses’ behaviour towards patients altered if they felt the patient had not responded in the right way. One respondent indicated that she felt a bit rejected by the patient if her suggestion or coercion was not accepted.

*N10AC “I think it affects the way nurses approach them (the patient), If someone complains a lot or expresses a point of view or is seen as not conforming or buzzes a lot,*

*you will get the .....oh not again what does she want.....I don't think it is obviously given off to the patient but they may well pick up on it"*

*N7AC "I think it gets the staff's backs up really because they think they know what is best for that patient and any variations on that I think is quite threatening to them, and I think that would come over in their manner as well unfortunately. I think they are less inclined to actually want to care for that patient, to be allocated that patient."*

This use of the power relationship to control and affect patient care seemed to be ignored or at least not acknowledged by participants, reflecting Tarlier's (2004) views that the influences of power operate at a subconscious, unarticulated and subtle level among nurses. Indeed this power relationship undermines the argument of caring as a moral imperative for nurses, as by its use, nurses breach the right of the patient to expect respect and support for their self-determination needs. This assumption of responsibility for patient's care through the nature of the nurse's knowledge base and expertise reflects a paternalistic approach to care that is, Draper (1996) suggests, strengthened by the affiliation to the medical profession involved in the care situation. One of the outcomes of this is that questioning and self-determining patients are found to be a threat to the nurses' perceptions of themselves as nurses.

By withdrawing, or wishing to withdraw from offering care to individual patients who have disagreed with the nurse, participants are reflecting the attributes of a poor nurse as defined by Redfern and Norman (1999b). These nurses had difficulty managing their negative feelings and emotions towards patients who have divergent views of the care required and cope with this by withdrawing from the patient and avoiding unpleasant aspects of the job.

It could be suggested that the difficulty of having care declined by patients could be solved if there was a shared philosophy of individualised care for patients that is mediated through the use of specific care plans.

## **Summary**

Allowing negotiation and choices to be taken by patients was identified by participants as being important, but also relied on there being a relationship with the patient. Negotiation was identified as being time consuming and often time was lacking so no real negotiation occurred, rather the participants paid lip service to the idea. Participants continued to be in power in relation to decisions and choices being made and this influenced the development of the relationship with the patient. Minor choices were identified as being most possible within the constraints of the organisation. Patient choice was mediated by the participants in relation to the patient's perceived dependence and often related to age. Participants seemed to be aware of the dichotomy this caused whereby their behaviour belied their offering of choice. Overprotection of the patient occurred due to fear of criticism from the organisation, and also as choice seemed to increase the participant's workload. A lot of time was spent by participants coercing and persuading patients to behave in the desired way, and this also affected the relationship often causing it to break down. Participants' seemed to find patient refusal difficult and resorted to referring to higher authorities to achieve their goals. If there was still no response to this coercion the participants noted a change of behaviour towards the patient, with feelings of negativity being expressed and withdrawal from interaction and care delivery.

## **Care planning**

Participants suggested that care planning approaches in their units were either ignored or paid lip service to by the nurses. This view reflects that of Allen (1998), Norrish and Rundall (2001) and Bleich (2002) which suggests this is an outmoded method of care in relation to new organisational demands and generates excessive volumes of paperwork. The lack of a shared philosophy of care planning prevented the development of meaningful care relationships with patients and reduced the potential for individualised care.

This ambivalence to care plans has been identified by Annandale (1996) and Allen (1998) where they are seen as defensive strategy against litigation or colleague criticism, but also of little use in helping nurses manage their workload. The difficulty with care planning, identified by participants, was two-fold.

Firstly to plan individualised care takes time with the patient that participants felt was not available due to pressure of care and organisational work, compounded by excessive paperwork requirements which was alluded to previously in relation to negotiation of care.

This links to the second difficulty; that of the use of standardised care plans. Most participants identified that the wards they worked in used standardised care plans. These are pre-printed sheets that should be applied to each patient who is admitted in order to plan their care. However, the standardisation and lack of individuality for care these sheets offered seems to have stopped the participants from using them at all.



*N10AC “care planning is a bit bad on the ward as well. We have got all pre-printed things and people either don’t bother, or because there isn’t a section for a patients particular care issue they leave it out.*

*N9AC “we have fifty pre-printed care plans for activities such as tracheotomy – where you have specific details of all the minute aspects of its care...the size of tube, when it was put in, when it needs cleaned next....”*

The main issue identified by participants was that these standardised care plans did not suit the patient’s needs and often they spent time individualising them to fit the patient’s needs. In order to individualise the care several other documents become attached to the care plan such as continence charts and falls charts. The completion of these was seen as taking time and potentially explains why some of the participants had stopped using them. However, other participants explained the need for these charts as policy decisions from the organisation, where it would prevent litigation should an incident occur. Unfortunately this has led to the charts being applied to all patients regardless of assessed need which is perceived by participants to have massively increased the required paperwork.

*N3AMC “you know the falls group has now produced falls paperwork and every time someone comes into hospital you have to do the assessment and then it’s meant to be done on a weekly basis.....so you can say yes I am assessing this patient for risk of falls, and I know it all comes down to legality but... and there are groups for everything”*

Another criticism of the standardised care plans were that they stopped the nurses from thinking about the care they were involved in, in relation to the patient’s needs.

Participants felt that nurses' just filled in the boxes without thinking about the individual.

*N15AC " it is just a case of well that is what they have got, that illness, put a tick in that box, and if you could involve them in the care plan as well then they could have more choice in their care."*

The general focus of the care plans is centred on activities that relate to patient's being 'cared for' with technical and functional aspects of care predominating. This fits with work by Kapborg and Bertero (2003) who suggest that one category of care is that of 'doing for', which is mediated through the nurse-patient relationship and presumes a passive patient. This reflects Milne and McWilliams's (1996) argument that organizations currently value 'doing for' activities that are measurable, more highly than 'being with' activities such as care planning.

Overall, participants felt that the paperwork and care planning was driven by organisational demand rather than being patient centred and this affected their response to undertaking the work as it was not often seen as relevant to their perceived role as nurses.

## **Summary**

Care planning was noted by participants to only have lip service paid to it or it was ignored totally. Participants were ambivalent towards care plans, identifying that individualised plans took a long time, which they did not have. However, standardised pre-printed plans did not meet patient needs so the participants ended up individualising them, thus using more time. Mainly the care plans were seen to be useful in

organisational terms as they proved things had been done and therefore could be used defensively against litigation or criticism. This had led to defensive use of all care planning rather than reflecting patient need so there had been a massive increase in the paperwork requiring completion. Many participants felt care plans, particularly standardised ones or pre-printed ones, stopped them thinking and were too focussed on technical care to fit with organisational demands.

## **Conclusion**

In discussing the nature of the nurse relationships in a care situation, participants felt the responsibility for developing the relationship was that of the nurse, not the patient. They identified several factors that affected their relationship and behaviour with patients, which included relative's views, patient's reciprocal behaviour. Participants all felt a relationship was necessary to allow them to negotiate care with the patient and to offer choices and decision- making in their care. However, they also indicated the reality was that although care was discussed, it was not negotiated, with the decision and power remaining with the nurse. Elements of coercive behaviour were described although not acknowledged as such. Finally the care planning process, along with other organisational issues was seen as non-helpful in the relationship with patients and more of a hindrance to their work than assistance. The issue of the organisational context of care will be addressed in the next chapter.

## CHAPTER 10

### NURSES AND THE ORGANISATIONAL CONTEXT OF CARE

In examining the qualified nurse's role in acute care of older people, the issues of nurses' explanations of their care work and how nurses perceive their relationships to older people have been discussed. This final chapter analyses the way nurses identify themselves in relation to the organisational systems and the effect this might have on the care they deliver.

A persistent theme emerged from the data in relation to the effect the organisational system had on how nurses constructed their care work, and their views of self as a professional. The coded categories and sub-categories that emerged from the data were complexly linked and had multiple strands of explanation and importance. Thus, although the discussion is presented in a linear manner it should be recognized that these sections interlink, and there is no hierarchical discrimination between them. The organisational context of care work for nurses contained two major categories, those of organisational demand and a broad category of effect on staff.

#### **Organisational demand.**

Participants articulated their views of organisational demand as those activities they were expected to undertake, by the organization, that were not seen as directly relating to their role as nurses who were there to deliver patient care. These activities mainly related to issues of changing work practices in light of organisational decisions. This

result is concurrent with a minor result established by Idvall and Rooke's (1998) work whereby focus groups of nurses identified obstacles to good quality nursing care that were often beyond the nurses directly involved in the care situation. However, similarly to issues previously identified in the literature review participants in this study found their experiences of care delivery to be affected by the organisational structures they worked in. Skott and Eriksonn (2005) suggest that many of the virtues included in the caring theories that are espoused by nursing have a tendency to underestimate the organisational structures that undermine caring. Similarly Dyson (1996) and Sourial (1997) imply that nurses' views of caring are not, in reality, congruent with their experiences of professional practice in the clinical setting, with conflicting paradigms and values involved in working in a hospital organisation (Milne and McWilliam 1996). Redfern and Norman (1999b) established that nurses identified organisational characteristics such as the care environment, ward environment and routines as being required as part of quality indicators used to define quality of care, along with those that reflect the processes of care.

One organisational factor defined by participants as one of the main stressors in their job was that of excessive paperwork. Participants were highly critical of the excessive amount of paperwork that ostensibly related to patient care. In particular, care plans of varying forms were seen as massively time consuming, and apart from the main details required by these, there were also several extra charts added. The participants were aware that maintenance of written records of patient care was important as a source of evidence of care. However, they saw these particular care plans as unnecessary to their work and thus often they were not completed or the information recorded was limited.

Allen (1998) established that nurses' attitudes to record keeping and care plans were ambivalent, noting that the processes were seen as more as a mechanism for management as part of a quality assurance exercise than a tool that assisted them in their everyday care work.

Participants acknowledged the organizations need for paperwork as evidence, as a means of protecting itself from litigation, which was also noted in previous work by Annandale (1996). However, paperwork was an aspect of the workload that they felt they had some control over particularly in terms of time usage, and thus they were often dilatory in completing care plans or ignored them. This, in itself is interesting because the patients recorded that nurses seemed to be very busy with a lot of paperwork.

*N5AC "it has the care plans in it but they were never carefully updated, so it probably comes from higher management that pushes the nurses to complete them.....oh its unbelievable, the amount of paperwork, and even on the computer when you discharge a patient, you know pages and pages some of the things you've got to fill in, diagnosis, severity of illness and, generally for nurses its not very relevant at all"*

*N9AC "there are plenty of protocols out there because in a court of law it just will not stand up and you know and I remember when I was on a night shift downstairs one day and I took all the care plans in and my colleague and I spent four hours updating 15 care plans and in the morning I said to my colleagues well I'll be seeing you all in court and they looked at me blankly, and I said if you do not update the care plans a lawyer will quite rightly think that you haven't done it but if you sign to say that you've done it they can't dispute that".*

Participants certainly believed that the paperwork was driven by organisational demand rather than being patient centred which reflects results by Allen (1998), Martin et al. (1999) and Karkkainen and Eriksson (2005).

*NIAMC “ we want to deliver a really good level of care but at the same time we’ve still got the paperwork to fill in, yeah it seems to dominate.....all these tools, all this paperwork that’s supposed to say to us we’re giving a level of care and this is what we’ve done for the patient. They (the organization) can’t come back and say we don’t give this care.*

*NI5AC “ and there’s so much paperwork for other things you have got to have paperwork for almost everything you do, and you fulfil your legal obligation, if you like. Its probably for some kind of audit type of thing so it is in fact easier for the auditor to find out what has been going on and look back if there’s been a problem and trail back through”.*

The first example (NIAMC) clearly indicates the ambivalence felt by the participants towards paperwork and its role in their care situation. A similar view to this was established by Allen’s (1998) results where considerable energy went into maintaining a satisfactory nursing record, although the nurse’s felt it took them away from direct patient care.

A further point of contention for participants seemed to be that often the paperwork that is developed comes from another non-care related activity instigated by the organization, that of working groups. Participants talked about these groups which were, apparently, set up by the organization as a means of improving practice. The groups consist of nurses drawn from the ward areas that look at specific areas of care practice and develop

protocols based on research and experience. The problem, however, seems to be that everyone (all clinical areas) is having these groups and it is taking up a lot of the nurses' time which participants feel could be better spent on patient care.

These groups also appear to develop paperwork that is then applied in a blanket fashion across the units regardless of patient need, which again has impacted on the time available for patient care and in fact also, along with standardized care plans, potentially can prevent nurses from thinking about patients as individuals. The value of these nursing records in terms of improved patient care seems difficult to establish as Moloney and Maggs (1999) discovered when attempting to undertake a systematic review of the literature. They conclude that there is no evidence to suggest that care planning and record-keeping have had any effect on patients' health status. This conclusion is in accord with that from Allen (1998) who suggested although care plans might be a reminder of aspects of care that could have been overlooked during a busy shift, the pressure of work meant that they were rarely reviewed prior to care being delivered and that nurses reported relying on the handover and colleagues' communications to gain the information they required regarding their patients.

Another organisational demand that has impact on the participants workload was the expectation that nurses would take on extended roles of practice such as extra clinical skills in venepuncture, 12 lead ECG recording and removal of arterial sheaths. These skills have been devolved from the doctors, and participants clearly saw them not as recognition of the nurse's value and worth, but as a means for the organization to meet working time directives for doctors' hours. Participants noted that these skills required training, this took time and also actually undertaking the procedures also took time but



no cognizance of this was given by the organization in either extra staff to cover the training nor recognition that perhaps other activities needed to be removed from the nurse remit to allow these to be added. Certainly Norrish and Rundall (2001) noted that restructuring of hospitals led to more time being spent on technical direct care activities and administrative paperwork.

*NI5AC “these expanded roles that we are getting into, which they (the organization) are very keen on, which is all very well and good but you don’t get the expanded time to do them...you are not getting the staff to cover or the extra time. That’s two or three hours when you would have been pretty busy doing other things. Those things now just have to go by the board”*

*N3AMC “However, these extra skills are having to be fitted into nurses’ time on top of all the other roles that nurses undertake and no extra staff have been provided to assist with this. I feel that at times this impacts on other aspects of patient care.”*

It is interesting that participants viewed the use of good practice groups and extended roles as having a negative effect on their role as nurses. The participants quite clearly felt their role was in delivering ‘hands on’ patient care to the best of their abilities and felt that these initiatives detracted from this role by diluting and reducing the time available to be spent with patients. Turkel (2001) suggests that the practice environment requires restructuring to allow maximum nursing time to be focused on nurse-patient interactions. It is quite possible the organization saw these extended activities as a way of valuing and rewarding their nurses, but the participants did not perceive it in the same way. The notion of nurses wishing to be valued will be returned to later in this chapter.

Devolved responsibility for management activities has also been identified by participants as an issue in delivering adequate patient care. Participants talked cogently about the nature of the managerial activities they or their senior colleagues were required to do. It was quite clearly recognized by participants, that many of the activities had been devolved to a fairly low level in the staffing hierarchy as a means of saving money. Ward managers (previously designated as Sister or Charge Nurse) were included in ward staffing numbers for delivering patient care. However, during the week they had responsibility for ensuring that staffing levels in several wards was appropriate, and recruiting agency or bank staff if there were gaps in the staffing. This activity took time away from the ward and active patient care, leaving their ward short until the situation was resolved. However, as G grades are not allowed to work at weekends, presumably for financial reasons, the responsibility is devolved to mainly F grade or if none available then experienced E grade nurses. Participants were highly frustrated by this organisational situation because although experienced E grades were given responsibility to 'carry the bleep' and identify the problems and what was needed, they were not given the authority to make a decision regarding employing agency or bank nurses and thus had to spend time finding an F grade or G grade somewhere in the hospital to actually get the staff and also to sign off the timesheets at the end of the shift. This then created more time away from the patient care on the ward. One suggests that by this approach the organization is creating a patient care workload problem for the ward staff by putting the budgetary needs of the organization before the needs of the patient. Organizationally they want the best of both worlds with the lowest level of staff possible doing the job but the decision-making and control being at a higher level. Some

more senior participants identified this approach by their managers to be a means of control.

*N7AC “I think the strings are held very tightly from us as a group, and although my manager has changed position into a more senior position its very much keep a tight control on these guys then nothing can go wrong. But I don’t think that’s good for our development.”*

*N3AMC “it means that the senior nurses are having to carry the bleep now, so ward managers take it in turns Monday to Friday in the morning and then pass it over to whoever is more senior in the afternoon and then at weekends the F grades are taking the bleep and that takes up quite a bit of time as well, and we are not getting anyone extra in when you are doing that because it is only 3 wards and it is only checking staff levels but some days that can take up a lot of time..... which then takes you away from the patient area, or other management jobs.”*

Adams et al (1998) when investigating ward management systems identified that most areas had a two-tiered nursing system. This system, whereby the senior ward manager retains a high degree of control led to nurses feeling least able to cope with the ward work, felt least valued and had least job satisfaction. Ward managers were also responsible for staff development and appraisal, budgeting and policy implementation. This again involved spending time away from the patient care area, in their offices trying to keep up with the paperwork involved. Participants acknowledged these demands on the G grades’ time and actively tried to give them protected time from patient care to allow them to do this aspect of the job

*N8AMC “our G grade is very, very lucky because she manages to come and work on the ward in the morning, but then they all have to do office work. And we feel we have to let her go, ‘go on away you go and get this done’.....but that means you are not a nurse any more, and the title ward manager... not a nurse.”*

## **Summary**

Changing work practices were noted as being an issue and were mainly due to organisational decisions and demands. The main stressor identified by participants was that of the excessive amounts of paperwork being required by the organisation. This mainly encompassed care plans and associated assessment tools. The participants recognised the need for this paperwork as evidence against litigation claims and also as a means of auditing care but were highly critical of the blanket application of these to all patients regardless of need. The paperwork also seemed to take a large amount of time to complete which took participants away from their main role of patient care. Some of the paperwork was developed through small groups of staff meeting to focus on one aspect of auditing care to improve overall practice. This again took staff away from patient care, and was perceived by participants as detrimental.

Participants were also expected to develop extended role skills but with no time given during their shift and no extra staff to cover their absence. Rather than seeing this opportunity as valuable and rewarding participants saw it as having a negative effect on their role, and as a means of budgetary saving for the organisation. Similarly, devolved responsibility of management activities was also an issue for more senior staff, however, their colleagues supported them by trying to free up work time for them to undertake these activities. Organisational demands in terms of non-nursing activities were seen by

participants as a significant factor in reducing the amount of time they could spend on patient care and thus had an influence on the quality of the patient experience, and also on their own perceptions of their role as nurses. The organisational context of care work also had an effect on staff morale through the perceived lack of value placed on them as individuals.

### **Effects on staff**

Working within the organisational context of health care had several effects on participants in terms of their professional identity and personal worth. A particularly pertinent aspect of this was participants' identification of lack of support and value from the higher levels of management which led to a cycle of stress and negativity. The theme of nurses' loss of trust in, and a wish to be valued by, the organisation was one that has recurred in several recent articles (Burke 2002, Johnston and Buelow 2003, Turkel 2001, Turkel and Ray 2004, Williams 2005, Laschinger et al. 2001, Adams et al. 1998).

Participants felt they had no involvement in the decisions made regarding care strategies and use of resources. However, there appeared to be an expectation from the organization that nurses would take corporate responsibility for the poor care that resulted from lack of resources although the nurses had no power to change the situation.

*N11AMC "you know there's nothing we can do about it, we are short staffed so just try and make the most of it"*

*N12AMC "I don't feel supported at all, there was one day there was just myself as trained and one other auxiliary that was new to the ward... the rest were bank and I was told to get on with it, you know here's the keys get on with it kind of thing."*

This notion of corporate responsibility as a nurse was also apparent in situations where stocks of fundamental care equipment such as incontinence pads or sheets ran out. This had a clear impact on the care that participants could offer and they felt responsible for the poor care delivered, although the ordering was undertaken by another nurse or stores manager who were not closely involved in the work of the ward and therefore perhaps were unaware of the impact lack of these resources would have. Thus lack of control in the work environment is an important factor in how participants felt.

Participants appeared to feel disempowered to effect or make suggestions regarding ways of working that might improve the care situation and seemed unable to use creative or non-standard approaches to care for fear of organisational reprisal of some form. It would seem that participants in this research were behaving in the same manner as those in a study by Wiggins (1997).

Wiggins (1997) established that nurses used rationalization, acceptance, looking for good points in management initiatives and keeping problems to themselves as a means of coping with the conflict induced by their own philosophy of care contrasting with that of the organisation. Participants in this research behaved in similar ways.

*N4AMC “there’s not much opportunity to offer suggestions in approaches to care, most information come from the top down, policies etc”*

*N15AC “they bring decisions up at ward meeting every couple of months, but no it’s very much this decision has been made.....its nothing to do with us.”*

It may be that the loss of the communal ward report and handover has encouraged this feeling of helplessness and powerlessness, as Latimer (1998) and Payne et al. (2000) both established that these processes allowed nurses to produce a sense of communal clinical domain and group cohesiveness.

This disempowerment extended to situations where the nurses' working lives were affected by organisational demand. Participants identified situations where, due to low patient numbers, at weekends, wards were closed and patients moved out to other areas for a few days. The nurses themselves would not know that there was a move of care environment until they arrived for duty, and would find a notice on the door telling them to contact the ward manager to find out where they were working. An extreme of this was that if there were still too many nurses for that shift, some of them would be given an annual leave day regardless of whether they wanted it or not.

*N10AC “ yeah, sometimes they will give out annual leave to people which is not great”*

*N9AC “say you know, do you want annual leave which is fair enough if you can say yes or no but sometimes people turn up for shifts and they (the manager/organization) say no we want you to take annual leave, which I don't think is fair.”*

This example typifies the participants' beliefs that the organization does not see them as individuals but rather as objects; or as one respondent put it, a little cog in a big wheel, and they are thus depersonalized.

*N8AMC “I feel she (nurse manager) just feels its kind of just keeping a cogwheel turning, every things rolling over and this is just her money that she's spending and she has to spend it in the most efficient way without thinking about the people that are involved.”*

This depersonalization is felt by participants to have a major effect on morale of staff as they do not feel part of the decision-making processes, having no power or potential to affect any change even in a minor way within the organisational structures. Any mechanisms for corporate communication that do exist are seen as management techniques to hand down information that needs acted upon, such as new policy, or where problems have arisen in the care situations that require nurses to take action to prevent it happening again.

*N15AC “really everybody knows although the Trust put out newsletters and that, trying to make it like we are all one big team everybody knows it is really driven by money when it comes down to it. At the end of the day you are just a number of staff on a ward with a number of patients”.*

*N5AC “We do have ward meetings, regular ward meetings. Well if there have been incident forms completed recently we get feedback on that, or sometimes they are a bit more serious than others.”*

The participants had lost trust in the organisation, and this is a cause for concern as Williams (2005) concludes that trust is pivotal in creating responsive organizations where individuals working in teams can respond willingly and rapidly to changing service demands.

This belief from participants that they do not matter to the organization is further strengthened through the perceived lack of reward offered to participants and thus the participants’ perception that they are not valued by the organization. Participants gave numerous examples of situations where they felt undervalued by the organization (in the



shape of the directorate nurse managers). These examples often related to educational opportunities, which were seen as a type of reward.

*N9AC “I wanted to do a specific course , and I self-funded that and went to London to do it and I paid for it myself and took 2 weeks leave to do it. So then I asked if I could do the critical care course and was told...’No you can’t do that because you have just been to London’. I went hang on a minute I paid for that myself and it was my own time, my own finances don’t penalize me for wanting to do well.”*

*N13AMC “you do get study days if you apply for them and you are not counted in the numbers that day on the staff.....your priority is covering the ward so you would be told you must come into the ward first. I mean there are study days you go on that are 9 to 4 and then you come it to the ward from 4 ‘til 9 to cover the shift. So you are on a study day and you have to come back here and you are absolutely shattered.”*

Participants felt there was a mixed message about the use of educational experiences. They were seen as a type of reward but did not necessarily reflect the individual respondent’s needs in terms of professional development. Often the courses participants were offered were those that the organization felt would meet the demands of the care environment. This again was viewed by participants as not being seen as individuals rather as a part of a corporate whole.

*N4AMC “there is little chance of further study or at least it’s very difficult. You are made to feel it’s a huge demand, but the expectation is that staff will keep up to date.”*

*N8AMC “I’ve been told by my line manager, no you are not allowed to do that course because we (our wards/patients) don’t have central lines. So it’s very difficult, or the response is yes you can go and do that but in your own time.”*

Participants felt the organization expected the staff to keep up to date but were not prepared to support them to do this through either funds or time. Thus the participants were clear that this meant they were not valued by the organization.

*N3AMC “people are like... well why should I go on a study day in my own time? I feel that it’s something the organization should be helping and supporting them in having so that they can go ahead and develop, and it’s really helping and stuff for them. Yes it is really lowering morale, its something they see as should be provided.”*

This lack of control over professional advancement, and also over their working environment meant participants had a very low level of job satisfaction, a result that reflects the work by other researchers (Tummers et al. 2002, Wiggins 1997).

Even at a more local level, there was a lack of valuing of the work and effort that the participants made, with colleagues being critical of each other and their work. This lack of support again affected the respondent’s feelings of personal satisfaction and being valued, which reflects McQueen’s (2000) work.

*N11AMC “It is very stressful sometimes on this ward, and we are all human as well, but I think, as long as we support each other. A lot of nurses, we don’t care for each other even though we care for patients. That’s crazy, even if you are having a horrible day, but if you give someone support it makes you feel better.”*

*NIAMC “I feel as though our role, nobody is irreplaceable, they’ll always find someone and that’s the feeling you get on the wards. No matter how much you give, how much you think you give, you never ever quite feel as though you matter”*

Similarly to results from Bassett (2002) participants were aware that often they were quick to comment on the negative aspects of the care, such as what hadn't been done, rather than acknowledging that the day had been difficult but also focusing on the positive things that had been achieved. Some felt that this would make staff feel more appreciated and positive in their outlook.

*N3AMC "I think it makes staff feel more appreciated. If you are saying look I know we've had a bad day, a busy day, but although we had all this coming on to the afternoon, look what we **did** get done."*

*N5AC "so actually everything got done, so that's quite satisfying."*

Generally participants maintained their feelings of worth and value from intrinsic mechanisms such as seeing patients improving or from themselves for doing what they saw was a good job or achieving a skill.

*N5AC "I did it first time and felt great because he (the doctor) had tried it 3 times and not managed."*

*N10AMC "so I was just with her and doing her physio and things like that , making sure I knew what physio's were doing with her and ...seeing her actually smile and being more positive about things was good."*

*N15AC "what you would like to do with the patients, you know its really nice when you have a really busy day and you do not get things done that you want to do and then the next day you just think right, for the next fifteen minutes I am going to sit down with this patient and I am going to do what I wanted to do yesterday and you actually get time to sit and do it and it just feels really good"*

These rewards and feelings of value were all achieved through participants meeting their own internal work goals, or from seeing positive success in terms of patients achieving their goals, methods identified in research by Astrom et al.(1995). Participants made no mention of positive feedback from patients making them feel valued although this was an area highlighted as important by Ramos (1992) and McQueen (2000). However, they did not seem to find this an issue as potentially the reward was seeing patients achieving the goal of being discharged and thus the participants felt they had achieved their goals and felt rewarded because of it.

Overall it seemed most important to participants that the organization valued and rewarded through high levels of job satisfaction and being valued as autonomous professionals with control over their work environment.

### **Summary**

The effect on participants of working within an organisational health care context included them feeling unsupported and devalued by higher management which led to stress and negativity. Lack of control of the work environment and non-involvement in decision making led to disempowerment of the participants, although there was an expectation from the organisation that participants would take corporate responsibility for poor care delivery. The participants felt the organisation saw them as a homogenous group rather than individuals which depersonalised them and had a major effect on staff morale. Trust in the organisation was lost, and further emphasised by participants as they did not feel valued by the organisation. Low levels of job satisfaction resulted from

lack of control over professional advancement and the work environment and led to colleagues being critical of each other and their work.

Feelings of worth and esteem were maintained by participants through intrinsic mechanism of seeing patients improve or knowing they had done a good job

## **Conclusion**

In establishing the participants' views of the organisational system and its effect on their care work, it becomes apparent that several interrelated issues affect the way participants feel in terms of care work.

First, organisational demands for completion on non- patient related nursing activities such as care plans and record-keeping were seen as over burdening and unwieldy with organizations developing more systems to prove they are achieving their targets, and to support them in litigious situations rather than as a means of assisting good patient care experiences.

Second, extended roles and activities devolved to the nurses were seen as time consuming, again taking the participants away from what they saw as their main job of caring for patients. Although these devolved responsibilities could be offered by the organisation as a means of valuing the participants, this was not how they were perceived.

Finally, the effects of these demands on participants have led to a loss of trust with the organisation with concomitant disempowerment and de-motivation. Participants did not feel valued or rewarded by the organisation and had little or no job satisfaction, thus

further adding to the conflict induced by working in an organisation that does not have a 'corporate' culture that recognizes and values caring.

The previous six chapters have explored the data results and research findings in relation to factors that influence the older person's experience of care and impact on how they construct their experiences. The following chapter (Chapter 11) offers a discussion of the complexities of care and allows the researcher to investigate and explain the way patients experience and construct their realities of care in the acute care setting.

## **CHAPTER 11**

### **THE COMPLEXITIES OF CARE - DISCUSSION**

This research undertook to establish the reality of the acute care experiences of older people through the researcher gaining an understanding of the features of older patients' experiences. By exploring the contexts of acute care described by the older patients and nurses, the generation of knowledge that leads to a greater understanding of how to achieve more focussed and person-centred nursing care will assist in the delivery of appropriate nursing care.

By adopting a care approach that recognises the older person's self-concepts, improved recovery rates, reduced length of stay and improved perceptions of the care received may be achieved. The development of a care approach that entails nurses and patients working in partnership towards a common goal of recovery should lead to cost-effective care delivered in a way that is acceptable to older people and nurses.

The nature of the care environment and its effect on the care approach can also be established with a view to addressing issues of role conflict caused by organisational, professional and nursing care demands.

The collation of the data analysis and discussion identified a number of issues in relation to the way older patients construct their experiences of care and the effect the nurses' interactions have on these experiences. These research findings are specific to this particular piece of research and the contexts of care described by the older patients and nurses.

Within the framework of social constructionism, the way behaviours, interactions and environment interact to affect each individual's realities allowed the researcher to explore the complexities of the experiences of care for older people in acute care settings.

The major strength of the research is the categorical aggregation that led to cross participant analysis of specific issues, and the assertions emerging from the care experience as a whole. This cross analysis emphasizes the intricacy of the experience of care, and enables the researcher to acknowledge the complexities of the care situation and then make naturalistic generalizations about the information gained from the research (Creswell 1998, Miles and Huberman 1994). However, the findings cannot be generalized because of the nature and limitations of the research method used.

The limitations of the research are intrinsic to the nature of qualitative research, the methodological approach, the acute care setting and the nature of the experiences of care as identified by two participant groups, that of the patient and the nurse.

An initial review of the literature base established a lack of knowledge in relation to where patients derive their expectations of care from, and also what patients identify as the main obstacles to achieving the care they want. Results from the data analysis chapters that illuminate and explain some of these issues will now be discussed within a proposed conceptual framework that illustrates the complicit relationship established between older people and nurses in acute care. The discussion will draw on details from the analysis of the patient and nurse data to assist in further confirming knowledge; and in some cases, identifying new knowledge of the way patients experience and construct

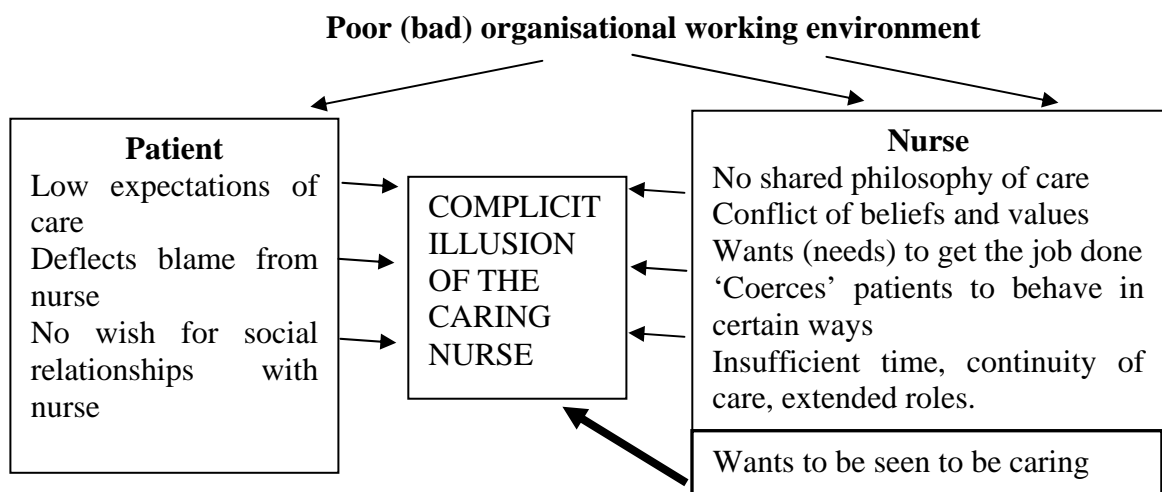


their realities of care in the acute setting. Where appropriate, the views of patients and nurses will be addressed together, to show the different interpretations given to the same situation.

### Conceptual framework

Under the overarching identified concept of a poor organisational working environment it was identified that older people and nurses enter into a complicit relationship to establish and maintain an illusion of the caring nurse. Dissonance exists between the patient and the nurse in relation to expectations of care approaches. However, to sustain their socially constructed view of the nurse as a caring person, patients deflect their criticism in relation to poor care away from the nurse and find explanations for the nurse's behaviour that allow them to maintain the illusion that nurses are caring. Nurses themselves, want and need to be seen as caring as this is the perceived reality of their professional education, values and beliefs thus although their behaviours and care approaches illustrate otherwise, they collude with the patients' to develop a reality that allows the illusion of a caring nurse to be maintained.

This conceptual framework can be demonstrated using a diagram.



This complicit relationship, established between the patient and nurse in a bad organisational working environment can be illustrated using three broad areas identified in the research

- Experiences of care
- Situational and organisational context of care
- Interactions in the care relationship.

These areas will be discussed from the patient perspective, followed by the nurse's perspective to show how collusion occurs in relation to the notion of a caring nurse.

### **Experiences of care**

The first broad area that emerged from the research and informed an understanding of the patients' construction of the reality of acute care was that of experiences of care. The patients had low expectations of care which is illustrated through discussion of the issues of rationalising of care, use and response to buzzers, decision making and choice, boredom and care approaches.

#### **Rationalising of care**

The uncritical and accepting responses of patients to the care they received in the acute care setting reflects the nature of the experience and how the patient has constructed that experience, as a means of making sense of their care reality. It would seem that patients construct a reality they can accept, as a means of being comfortable within the acute care environment. As Sumner (2001) suggests, 'playing the game' allows the patient to

rationalize the care they receive. This, the patients achieve, through explaining episodes of non-facilitative care as being due to the demands of the anonymous organization rather than the nurses immediately involved in the care. By devolving the blame, patients can prevent themselves from feeling negative and ungrateful about their care experience in an individual setting. However, as the age group of the sample is one where they can remember health care prior to the instigation of the National Health Service, even criticism of the organization causes them cognitive dissonance, with reiteration of how lucky they are to receive free care. Thus in order not to appear ungrateful, patients indicated and affirmed a positive care experience. Similarly, they are then not critical of the nurses' care behaviours, even when the evidence is that care has been non-facilitative. This reconstructing of negative experiences, into a more positive light, or at least being able to explain them away, would seem to be crucial to the patient's construction of their care experience. In their mind; and as identified by James (1992) and White (2002), nurse = good = caring and to criticize or complain about the caring behaviour would be to challenge and destroy their socially constructed idea of the caring nurse. The outcome of this could then cause the patient to confront, to them, an unacceptable reality of hospital care where nurses did not behave in the expected caring manner.

In gaining an understanding of how patients construct their care experiences, new knowledge emerged. It became apparent from the analysis, that the patients compared their own experience of care, against those reported in the local and national media. By doing this they were able to rationalize their experiences as good, because the

experiences of care they were comparing against had been reported as so bad that they saw themselves as lucky to have received the quality of care they had, and their care as good. To this end, television and press coverage of extreme examples of poor care in the NHS would appear to benefit the organization in the long run, as patients were grateful their care had not been as bad as that reported.

Data collection for the research coincided with several episodes of negative media coverage regarding patients' experiences in the acute setting, both locally and nationally. It may be that complaints regarding poor care increase when there has been little negative reporting in the media. This could be due to patients' expectations of care being higher due to a lack of comparative situations. There is potential for further research into this area.

The patient experience is also influenced by the episode of care, the context of the care situation and the individual patient (Stockdale and Warelow 2000, Aiello et al. 2003). Patients in this study explained care situations in relation to their own perceptions of level of illness. Several identified their need for care as minor in relation to other patients in the ward, with some specifically defining themselves as feeling in a fraudulent role. This use of their own perceived level of illness allowed the patients to explain and accept the level of attention and promptness of care received from the nurses. Specific activities by nurses such as the use and response to buzzers, decision making and choice, boredom and care approaches were used to illustrate these explanations.

Use of; and response to buzzers.

The patient participants give details of nurses not responding quickly to buzzers<sup>4</sup> for assistance, but rationalize these by suggesting that the nurses may well be dealing with patients who are much sicker than they are, and therefore, by implication, more worthy of the immediate attention of nurses. This notion of being deserving of nursing care, or in hospital fraudulently, may stem from the age group of the sample, who, potentially still retain a wartime mentality of stoicism and 'getting on with it'. There seemed little knowledge or expectation of patients' rights within the sample group, and the notion of rights was never overtly mentioned or alluded to. The belief held by participants, that requests should only be made with good cause, suggests that care expectations in this group are limited and thus their expectations of care are met through their experiences.

The use of buzzers seems to epitomize the way older patients construct their care experience. The patient participants clearly believe that requests for support or assistance should only be made with very good cause, and were critical of those patients who did not respect this unwritten imperative. Explanation of this poor patient behaviour with buzzers, and to some extent, other demands was given; with emphasis made of the changing societal values towards nurses, health care in general and people's increasing selfishness. This participant group felt that other generational groups expected far too much in the way of care from the nurses, with younger people taking less responsibility, and making less effort to contribute to their care. However, interestingly, this participant group did not place themselves in the category of older people; this was

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<sup>4</sup> The use of the term buzzer was universal in all participants although the established term for this piece of equipment is a call bell.

because they were in acute care settings, not continuing or residential care, and they assumed they would be returning to their own lives in the community following the acute care experience. Further work relating to how people situate themselves in terms of their health care requires to be undertaken to facilitate greater understanding of their perspectives.

Furthermore, the patients expressed a firm belief that, even if there was no immediate response to the buzzer, someone would come eventually. This belief persisted even when the evidence suggested it not to be the case and may reflect the construction of 'nurse being caring', thus illustrating the development of the illusion of the caring nurse.

Decision making and choice.

When it came to decision-making and choice within the care experience, patients valued, and felt they were given, the opportunity to make choices regarding the minor aspects of their stay in the wards, such as meal options, bath and shower times and bed times reflecting Haggman-Laitila and Astedt-Kurki's (1994) results. However, the patients were clearly able to articulate that these choices had to fall within the need of the organization for routine and structure and this impacted on their experiences when making these choices. Thus the patients deflected any blame from the nurses by identifying the organisational need as the factor that influenced their care experience. Unlike previous studies (Irurita and Williams 2001, Koch et al. 1995, Redfern and Norman 1999a) the patients did not express that this was depersonalizing or disempowering and expressed the view that there needed to be systems, routine and

structure to enable smooth running of the ward. Patients also recognized that their own personal choices would impact on others sharing their care environment and therefore, recognized the need for negotiation and compromise within what they were requesting.

Patients were also aware of the approach nurses took in terms of ostensibly offering them the decision making choice, but in reality, by the way the nurse couched the question the assumption was that the patient would agree to the nurses preferred option.

The patients, although recognizing these strategies, usually acquiesced to the nurses as the decision was not significant enough to cause them difficulties in accepting it.

However, as Haggman-Laitila and Astedt-Kurki (1994) point out this may reflect the nature of the role the patients had adopted.

Similarly, the patients stated categorically that, at certain times in their stay, they neither wished nor had the energy to make decisions and choices. This particularly related to when they were first in the hospital and relatively unwell and reflects the work by Stockdale and Warelow (2000) and Nordgren and Fridlund (2001).

However, the reality of the patients experience is one; not of being disempowered but rather, as they do not know the rules of behaviour for acute hospital care, of not wishing to do the wrong thing and upset the systems and routines. This, coupled with their perception of nurses being busy, prevents them from asking for information that would allow them to be independent, or undertake activities that would relieve the boredom of their hospital stay, such as visiting the coffee shop.

### Boredom

Patient participants were quite clear that boredom had a major effect on their recovery; with lack of physical activity or mental stimulation, other than that undertaken as part of

their treatment, causing them to become more dependent. A means of ameliorating this boredom was the fact that most patients were in shared rooms with others and they could chat, or assist each other, which had a positive effect on their well-being as they felt of value and worth. However, the layout of the physical environment was seen as detrimental to encouraging social interaction as patients all sat by their own beds with no communal sitting area available, or if areas were available the patients did not seem to feel able to go there without permission. Patients also felt a commonality of social background was desirable, and were more inter-active with each other when they had common interests.

This desire on the part of the patients to actively recover has resonance with Irurita's (1996) and Coyle and Williams's (2001) work on retaining personal integrity and identity, and having control over aspects of one's life whilst in hospital care. This, however, seemed to be related to the personality attributes and approach to life the patient held as noted by Macduff (1998). Those patients who felt frustrated by non-facilitative care approaches, and who were keen to be involved in their care decisions, often attempted to be self-determining in their care and take the initiative with regards to finding out about their drugs and attempting to be self-caring. This approach at times was thwarted by the patients' lack of knowledge and information regarding equipment, drugs and nurse's knowledge along with the issue of not 'knowing the rules'. What might be seen as negative care experiences because of this are, in effect, translated by the patients into a positive experience by rationalizing them as learning experiences. They also absolve the nurses from the responsibility of telling them about these things by assuming other patients had previous experience of them and therefore, it is they



themselves that are at fault. This self-criticism regarding not asking, questioning or challenging nurses about their care reflects the idea that there is specific unspoken behaviour required of being a patient and was seen as a negative aspect of themselves, whereby they were not trying hard enough to get well, thus were not contributing enough to their care.

This was also illustrated in the care approaches used towards patients, with patients being unable to assess to what extent they could participate in their own care, as they were unclear as to the expectations of the nurses for self determination of care. The patients identified maturity of the nurse ( in terms of their nursing experience) as being important in their experiences of care, and felt more comfortable to ask questions of those nurses who appeared to be more mature in their role. Possibly the patients were to some extent protecting their own integrity by this behaviour as they felt they would get an appropriate response from the nurse, or they were protecting the less mature nurses from being placed in a situation they were not able to deal with.

Nurses also reflected on the patient's experience of care through the issues use and response to buzzers, decision making and choice, boredom and care approaches.

From the nurse participants perspective they perceived older people to be less demanding as patients because they did not use the buzzer a lot, and this was seen as the patients respecting the nurses, and acknowledging that the nurses were busy. Interestingly, the patients' knowledge regarding the nurses being busy came from the nurses, who told them they were very busy, and also patients deduced this busyness through observation of nurses' behaviours. Similarly, the nurses deemed the older

patients to be less demanding, and suggested that older patients respected them more than the younger ones, and understood that they (the nurses) were very busy and therefore did not want to bother them. Nurses explained this view by noting that older patients do not use the buzzers, ask for attention or make what were seen as unnecessary demands of the nurses. What the nurses seemed unaware of was that their own behaviour, in terms of tardy response to the buzzer and indications of being busy, could have significantly affected the way older people use the buzzer.

The nurses did not seem to feel a slow response to a buzzer from an older patient was inappropriate, even given that older people only buzzed when absolutely necessary and one would therefore expect them to respond quickly knowing that it must be a necessary call. This may be a protective mechanism on behalf of the nurses, who by ignoring the demand made by a buzzer can protect themselves from threat to their personal and professional integrity caused by inability to perform the job to their satisfaction (Irurita and Williams 2001) and again defends the illusion of a caring nurse.

Although not articulated by the patients or nurses, it is possible that nurses used their response to buzzers as a means of control over patients, and to some extent established behavioural conditioning of patients not to buzz, through non-response to the buzzer. This would reflect Tarlier's (2004) notion of unconscious use of power by nurses. This unconscious use of power could also explain the idea identified by patients as "the nurses' minute" which was elastic and related to the time taken for a nurse to return to a patient to offer assistance.

## Decision making and choice

Nurse participants also identified that patients were given choices, and these choices were acknowledged as the minor ones identified by the patients. Similarly the nurses also identified the need for routine to allow the ward to function, although as Wiggins (1997) and Philpin (2002) indicate, the use of routine reduces nurses' stress and anxiety. Therefore, the nurses' desire for routine could be explained as a means of them protecting themselves from unnecessary stress in the workplace. However, it appeared that nurses mediated the potential for the patient's choice depending on their own interpretation of the patient's abilities and dependence levels. This was done without consultation with the patient concerned and had the effect of constraining patient's behaviour and in some cases making patients who had attempted some independent activity such as dressing feel they had been in the wrong by doing so. Nurses also appeared to spend time in coercing and persuading patients to behave in a manner they deemed appropriate. This was particularly the case in relation to drugs or if a patient expressed disagreement with the nurse's decision. This use of expert knowledge and professional authority by nurses is often explained away as being patient-centred because the nurse feels they are working in the best interests of the patient. However, should a patient not acquiesce to this, a control impasse arises which then seems to affect how the nurse behaves towards that patient (Draper 1996, Ramos 1992). The nurses ascribe explanations to the patient's behaviour towards independence in hospital, subscribing to the view that the admission to hospital has disempowered the patient and thus they do not want to make choices and decisions about their care; or that the older generation the patients come from means they do not expect to make decision about

their care stay, with nurse and doctors making the decisions. This use of assumptions therefore, prevents patients from behaving independently and also results in them being assisted in activities they are able to do themselves.

### Care approaches

Many of the nurse participants identified that the personality of the patient affected their approach in the offering of information, and this relied on the nurse reading cues from the patient. Often the effect of the relative's anxieties and expectations regarding the patient's care affected the amount of independence the patient was allowed, with nurse's being overprotective to avoid criticism from the relatives. Nurses often felt in a quandary as they suggested that not all patients wished to be self-determining regarding their care, but the nurses felt they should have control over those aspects of their care and thus there was a tension between the nurses' care approach and that of the patient. Ramos (1992) notes that when patients and nurses espouse the same values and beliefs about care a strong reciprocal relationship can be formed which facilitate the care experience.

However, not only did nurses have difficulties with a shared philosophy with patients, they also did not seem to have a common shared philosophy of care with their colleagues, even when working in the same ward, and thus the patients were receiving mixed messages all the time regarding appropriate behaviour in terms of their self-determination of care. This impacted on the way the patients felt they could participate in their care, as they were unclear as to the expectations for self determination of care. As Haggman-Laitila and Astedt-Kurki (1994) suggest the nurses appear to lack

knowledge of the patients' experiences, or that the whole issue of the patient experience is taken for granted, and of limited interest to the nurses.

Interestingly nurses themselves also wished to have personal integrity and identity in relation to their care giving. This was threatened by the lack of a shared philosophy of care as they felt there was scrutiny, and implied criticism from their peers, of their care performance. This conflict of beliefs and values, along with differing personalities and care approaches within the nursing team clearly affected the nurses' abilities to work as an effective team and thus had a major impact on the patient experience. As the nurses were unable to deliver care in a way that matches their own beliefs and values they became frustrated and dissatisfied. Thus their own identity as a caring nurse was affected leading to stress. To prevent this threat to their personal integrity as a nurse they withdraw from involvement and interaction with patients (Williams 1998). However, by withdrawing from interaction the nurse fundamentally challenges their own beliefs and values regarding caring and thus may reduce their self-esteem in their role as a nurse. This lack of self value and esteem can lead to further stress for the nurse, and further challenge to their personal integrity.

The wish for a personal identity may also explain the nurse's response when the patient ignores, maintains a contradictory view or challenges the information and care offered by the nurse. Nurses may feel threatened in their professional role by someone who wants to be involved and active in the decision-making aspects of their care. It would seem that the maturity of the nurse in terms of their role identity has an impact on their ability to deal with these issues and the more junior nurses struggle to maintain their

personal integrity as nurses in the face of these issues. As Brilowski and Wendler (2005) suggest, the ability to vary care depending on circumstances, environment and people is an aspect of care that is learned through experience, and therefore, the nature of the caring approach will change or evolve as a nurse becomes more proficient in their practice.

However, it appears that the patients did not specifically see nurses as individuals, more as a homogenous group whereby a nurse = a nurse, and this view of nurses as interchangeable was also apparent through the organizations' behaviour and thus the nurses desire to have a personal identity and be valued is currently unattainable. The failure of the organisation to develop a corporate culture that values caring in its totality is a serious threat to the patient experience (Milne and McWilliam 1996) and thus nurses are struggling to maintain and preserve their beliefs and values of humanistic caring within a non-caring environment (Turkel 2001). If the organisation developed a culture that cared for and valued nurses, the nurses would be enabled to convey their caring values to patients and relatives thus improving the patients' experiences of care.

## **Summary**

In relation to experiences of care it is apparent that patients in this research used several strategies to allow them to rationalise the care they received. Two of these, devolving blame to the anonymous organisation and comparison with media reported incidents of poor care relate to external factors. Comparison of perceptions of levels of illness and personal values and beliefs also influenced how patients constructed their care experience in relation to time of nurse response, use of choice and negotiation and

routinised care. The nurses' effect on the construction of the care experience relate to issues of power and coercion, information giving, shared philosophies of care and maintenance of personal integrity and identity. An understanding of the organisational context of care and its effects on the care experience is crucial in developing knowledge of the patient's construction of their care experience.

### **Situational and organisational contexts of care.**

The second broad area to emerge from the research was that of the situational and organisational contexts of care. The impact of these contexts of care on the overall care environment will also influence the patient's experiences of care. This area is addressed through two issues; that of continuity and consistency of nursing staff and resource issues.

Other than the work by Koch et al.(1995), there appears to have been no attempt to establish patients' understanding of the organisational context on their care. To this extent new knowledge has emerged in this research that relates to this area of care.

#### **Consistency and continuity of nursing staff.**

The most persistent issue identified by patients in relation to their experiences was that of the lack of continuity and consistency of nursing staff involved in their care. Contrary to governmental agendas relating to having a named nurse (Department of Health 1999), none of the patients interviewed were able to name a nurse responsible for their care. However, this did not appear to be an issue for the patients reflecting the idea that they see nurses as a homogenous interchangeable group; and as long as the nurses were able

to do the job required, the patients were quite happy. Although Salvage (1990) suggests research is required in this area, nothing appears to have been undertaken to date and this would seem crucial in terms of gaining and developing nursing care that matches patient expectations. Why this research was never undertaken may be because at that time the emphasis in the literature was on the concept of caring and what made a caring nurse. For nurses to be seen as a homogenous group would devalue and negate that emphasis. Further research is needed to establish a detailed knowledge of patient's requirements regarding nurses.

The nature of the working patterns (12 hour shifts) and the method used by the ward in allocating nurses to work with specific bays of patients were identified by the patients as being a cause of this lack of continuity. It was also used as an explanation by the patients for why they did not ask questions or for information, as the nurses were not consistently available and thus no rapport or relationship developed unless the patient's stay was of some length.

The patients clearly indicated that they felt the nurses were very busy and there were not enough of them, but this view was based on information given to them by the nurses, who persistently told them how busy they were. Similarly, because the nurses were not always accessible or visible to them, they made the assumption they were busy looking after patients elsewhere. Patients did not specifically identify or explain how they knew that the nurses were busy, and it seemed as if this was a self-generating belief between patients and also fuelled by media representations of shortages of nurses in the health service and adds to the notion of patients colluding to maintain an illusion of caring nurses.



Patients per se did not comment on lack of resources in terms of items of care but clearly identified organisational aspects of care that affected their experiences. These fell into the category of the care environment with comments relating to meals and food availability, cleanliness of wards and personal effects. Patients were pleased to be able to select their meal choices, but were well aware that choice and quality was restricted by the nature of the organizations catering system and within that parameter the overall view was the food was excellent. Comparisons were made by the patients to meals they had had in different care setting within the same local Trust area as a means of making sense of their experience.

However, cleaning of the wards was a major aspect that affected the patients' experiences, partly this was highlighted as an issue because of high media attention which had raised the patients awareness of the situation, and partly by comparison to their own expectations of hand-washing and cleaning routines. Again nurses were exonerated from their responsibility in maintaining the cleanliness of the environment with the system and organization being seen as having the prime responsibility for any faults.

A final aspect of the care experience that affected patients was the assumptions made by the organization regarding washing of personal clothing. Again the lack of facilities for patients clothing to be washed was based on the premise by the organization that they would have someone able to take the washing home and do it for them, which was not always the case, leaving some patients in the invidious position of having nothing clean

to wear for several weeks. Nurses were again exonerated from blame with it being clearly laid at the door of the organization. This again reflects the patients and societies belief of the nurse being fundamentally a good person who will not do patients harm by their behaviours, although sometimes the experiences of the patients contradicts this view.

It is however important for patients to maintain this belief as it directly impacts on their relationships and interactions with the nurses. It seems that patients accept that the care they receive is delivered within an organisational context and are therefore realistic and accepting about the nature of the care available (Davis 2005, Macduff 1998). They acknowledge that there are issues and problems inherent within this care situation but seem to tolerate them as part of their understanding of constraints imposed by care in a large hospital.

#### Nurses views on continuity of care

Nurses also identified lack of continuity of patient care as an aspect that affected their ability to deliver care in the manner they felt appropriate, but felt that 12 hour shifts both helped and hindered their ability to provide consistent care. This depended on when the patient was admitted in relation to their off duty pattern.

A further problem in relation to staffing is the perception from the nurses that they did not have enough staff, although they were at their establishment numbers for the organization reflecting results from Idvall and Rooke (1998) and Williams (1998). What seems to be the issue here is a perpetuation of the idea that nurses per se are too busy. However, the evidence to support this is lacking and it may be a perception based on

nurses feeling undervalued by the organization along with their own beliefs and values about what is appropriate staffing. Some nurses recognized that it was not the number of staff that was an issue but was more to do with the nurses' attitudes and approach to work along with lack of team working and communication. Adams et al (1998), Norrish and Rundall (2001) and Lundgren and Segesten (2002) have established that current nursing practices do not fit the organisationally defined ideals for team working. The variability in availability of numbers and grades of nursing staff and unpredictability of workload militate against the requirement of a system for continuity of caregiver. The move to 12 hour shifts and reduced handover time has led to the use of taped reports where there is no actual personal transmission from nurse to nurse leading to lack of clarity and miscommunications regarding patients and their care (Adams et al. 1998, Bleich 2002). Similarly Latimer (1998) and Payne et al (2000) have established that handovers contribute to the complex functioning of a ward and allow development of group cohesiveness. The lack of face to face group handovers potentially has led to the lack of a shared philosophy of care in the ward, although this issue could be addressed by the use of patient care plans. However, the care plans themselves were seen as an organisational requirement that the nurses paid lip service to using rather than seeing them as a means of providing continuity and effective patient centred care. Bleich (Bleich 2002) and Karkkainen and Eriksson (Karkkainen and Eriksson 2005) indicate that documentation and acts of charting information are based on previous shift patterns of working that do not reflect the current work patterns. Introduction of new designs of documentation and caring models are required to reduce the multiple disjointed and non-standardised forms currently in use.

## Resource issues

Many of the issues that hindered care work, in the views of the nurses, related to poorly designed and executed organisational systems of staff and stock management. Extended roles for nurses were seen as a huge barrier to managing effective patient care and impacted on staffing levels on the ward. The nurses had a dilemma here, as extended roles were to some extent seen as valuing their abilities, but on the other hand took them away from their primary concern of patient care. They were also seen somewhat cynically as a means whereby the organization saves money, again fuelling the feelings of lack of value being placed upon them as nurses.

Stock management was also a major stressor with nurses although they had no control over the ordering of certain fundamental care items. Lack of these care items directly impacted on the quality of care the nurses were able to deliver and although they had no part in the ordering of these goods they felt a corporate responsibility for the effect it had on patient care.

## Summary

In identifying situational and organisational contexts of care, and patients understanding of these, new knowledge has emerged. Common issues identified by the patient and nurse were lack of continuity and consistency of staff, further the issue of staffing resource and organisational practices affected nurses' ability to deliver care. Patients' experiences of care were also affected by organisational aspects such as cleaning, meals

and personal clothing; however these were tolerated as part of the understanding of constraints imposed by care in a large organisation.

### **Interactions in the care relationship.**

The third and final area to emerge was that of the interactions and relationships the older people had with the nurses. Within the results it became clear that there was a major dissonance between the older people and nurse perspectives which caused difficulties for both parties in their interactions.

#### **Older peoples' perspectives of the interactions**

A feature of the patient's experience of acute care was the interactions they had with nurses and the nature of the relationship. One particular issue that influenced how patients felt about their experiences was the accessibility of nurses, with patients expecting to see nurses around the care environment although not necessarily undertaking direct care with them. The expectation that nurses would be visible was a feature of the patients need for reassurance and confidence that assistance was easily gained should it be needed. Coyle and Williams (2001), Attree (2001a) and Moyle (2003) all established that nurses who were visible and potentially accessible were viewed in a complementary light by patients.

The layout of the environment had a significant effect on this expectation with some wards facilitating this expectation through its layout as nurses were clearly visible around the area. Although patients were expecting to see nurses in the vicinity, they still were reluctant to make demands on the nurses for assistance unless in extreme need.

The visibility of the nurses seemed to confirm the patients' views that nurses were always busy and also allowed them to construct their care situation as being of lesser need than other patients. There was no particular desire from the patients for these nurses to be specifically a named nurse just as long as they were accessible and qualified to offer the care required should it be needed. This fits with Halldorsdottir and Hamrin's (1997) and Nordvedt's (2001) results whereby the important relationship for a patient is based on competency and ability to deliver instrumental care. However, Williams (2001b) suggests a social relationship can contribute to the patient's well-being and recovery. As the patients in this study do not feel the need for this relationship, its lack in their care is not a loss to them and therefore, if it exists is seen by the patients as added value.

Although previous studies had indicated that patients wished social relationships with the nurses this was not case with this particular group who seemed to be accepting and trusting of nurses as a global group (de Raeve 2002). In reality several patients enjoyed the fact that there were a lot of nurses available as they then had different people to talk to, and some felt that patients should make an effort to interact with the staff as part of their role of a patient. Patients identified that there was limited time to develop relationships of any sort with nurses, partly due to the shift patterns and lack of nurse continuity, and also sometimes due to the limited length of stay in the care environment. Patients did not seem to need or see the benefit of a close nurse relationship, identifying that they used family, friends and external support for their emotional needs. These

views were diametrically opposed to the beliefs and views of the nurses and the potential here is for a breakdown in the whole care experience due to misunderstanding.

#### Nurses perceptions of interactions

A major area of cognitive dissonance exists between the patients' expectations regarding relationships, and the nurse's beliefs and values about being a caring nurse. Since the inception of the quest for clarity in the concept of caring in nursing; an emphasis, first identified by Morse, Solberg et al (1990) as a therapeutic relationship, has grown through the nurse educational process contributing to the development of shared philosophies of care (Sanford 2000, Welch 1999). Over time this therapeutic relationship in its original sense of instrumental care, has changed emphasis, focusing more on the psychotherapy interpretation of the term therapeutic (Salvage 1990, Staden 1998, Stickley and Freshwater 2002).

This presents a problem for the nurses who perceive the need for time, and sharing of self in developing a therapeutic relationship, whereas the patients are accepting of the original notion of a therapeutic relationship. By subscribing to the notion of 'caring about', the nurses relationship is not just tied to instrumental nursing care but to all aspects of nursing, and thus they feel when they are unable to achieve the ideal, that they have breached the expected trust between the patient and nurse that is due to being in an organization (de Raeve 2002). However, it is apparent from this research that patients do not have the same expectation of relationship therefore to them there is no breach of trust.

The nurses, particularly those of greater maturity and experience, read cues from the patients as a means of establishing whether or not patients wished to enter into an interaction with them, although they were unable to indicate whether they read the cues correctly or not. They also used visibility to maintain a superficial relationship of contact with the patients. This idea of visibility concurs with the patients wish to see nurses about the area even though they may not wish to interact with them. The nurse contact in these brief visibility situations was done by a wave, smile or quick comment as they passed the patient, which made the nurse feel they were achieving their role as a caring nurse. However, nurses were also skilled at avoiding eye-contact, or using delaying tactics to control the demands made on them by the patients and also their relatives. This potentially was used as a protective mechanism when the nurse felt she was unable to deal with the situation or its emotional demands (Draper 1996, McQueen 2000). The need for the nurse to maintain their belief of being a caring nurse, which has been engendered through societal and educational processes, essentially causes tension and stress in the working situation as organisational demands and patient requests conflict. Thus the nurses' use behaviours, such as not offering negotiation and choice to the patients, that have an impact on the patient's experience of care but protect the nurse from acknowledging feelings of negativity and low self-esteem.

### Challenges of choice

Challenges exist within the nurse-patient relationship in relation to patients making decisions relating to their care, or not. Many patients indicated the difficulties they faced in terms of decision making, and choice, and the fact they do not challenge or



question the care. This might result from the patients feeling or knowing that to do this would affect the relationship they had with the nurses in relation to their care (Kapborg and Bertero 2003). Although the patients did not specifically articulate this concern, the nurses indicated that should patients not respond to their coercion tactics the nature of the relationship changed with that patient, partly because the nurse felt rejected in their caring role. Specifically the nurses identified that it was important to have a relationship with the patient as this assisted them in negotiating and cajoling the patients to accept the care.

The use of cajoling and coercion may be perceived by the nurses as a 'caring' behaviour, thus to have it rejected, rejects them as caring professionals and thus damages their self-image (Greenhalgh et al. 1998). Nurses maintained it was acceptable to spend time cajoling and coercing patients particularly if the nurse felt it was important, and they seemed to find it difficult to accept that an older person might have a differing view of the care required. This firmly situates control of the care with the nurse regardless of the rhetoric in relation to patient- centred care, although it appears to be an unconscious behaviour on the part of the nurse (Tarlier 2004).

## **Summary**

Dichotomy lies within the area of interactions in the care experience, with patients wishing to see nurses around the care environment although not directly interacting with them. This caused the patients to feel reassured and confident that assistance was available should it be needed. There was no expressed wish from the patients to have a social relationship with the nurses. Contrasting with this was the nurses long held view

that to be good caring nurses a therapeutic relationship was crucial. However, the organisational environment prevented nurses from developing or maintaining this relationship leading them to develop strategies to protect their views of self, but which had an impact on the patient experience. The major strategy used was that of coercion and cajoling to gain the desired result rather than using a patient – centred approach through negotiation.

## **Conclusion**

This chapter has drawn on the presentation and initial analysis of the data in the previous six chapters to develop an in-depth discussion about older people's and nurses experiences and constructions of care.

This has been achieved through the development of a conceptual framework that identifies the collusion between patients and nurses in maintaining an illusion of a caring nurse. Through critical analysis, the different aspects of the care experience within the context of acute care settings have been explored. Identification of three broad areas was achieved which assist in understanding the experiences of care, the situational and organisational context of care and interactions in the care relationship. Through this understanding it can be seen that aspects identified by Brilowski and Wendler (2005) as the antecedents required to maintain the patient's experience of care, and nurse's job satisfaction exist within the care setting. However, it is apparent from the analysis that these antecedents of trust, rapport, individual and organisational commitment are interpreted in differing ways by the patients and nurses. Further the antecedent of

organisational commitment to caring seems to be of crucial importance to the nurses, although not of relevance to the patients.

This discussion has allowed the identification of several areas requiring further research. Further proposals can be made regarding aspects of the experiences of care that may allow the organisation and nurses to maximise the patients' experiences of care. These will be discussed in the concluding chapter.

## **CHAPTER 12**

### **CONCLUSIONS AND REFLECTIONS**

This chapter addresses issues of the new knowledge gained for the researcher and also for the profession of nursing. This is achieved through reviewing the major themes to emerge from the research and drawing on these to establish this research's contribution to the knowledge of older people's care experiences. Following an overview of the research, the personal knowledge gained by the researcher will be addressed, and then issues of importance to nursing and the health care organisations will be highlighted.

This research study was designed to explore older people's experiences of acute care and to gain an understanding of the ways the older person constructed and made sense of their experience. The role of the nurse within this process and the organisational context of the care setting were also examined as a means of gaining a total picture of the influences on the older person.

The research aimed to:

- Examine the experiences of older people within acute health care settings.
- Examine qualified nurse's experiences in relation to older people, in the context of acute care.
- Locate older people and nurses experiences in the context of two organisational settings

Within this framework several objectives were defined to focus the research. These were to establish how older people define themselves within the context of hospitalisation and society, to analyse the nature of the older person's interactions with nurses and the effect the interaction has on the person's recovery, to examine how nurse's define themselves in relation to caring for older people and to analyse how nurses define themselves with respect to their professional identity and socialisation within the organisational framework of acute care.

The use of qualitative methodology along with critical inquiry and analysis of the data, and utilising concept maps as a strategy to assist in the complexity of the analysis, three broad areas that impact on the older person's experience of care emerged from the research. These were:

- experiences of care
- the situational and organisational context of care
- interactions in the care relationship

### **Personal knowledge and reflections**

The researcher has identified several areas of knowledge in terms of personal outcomes that have been gained through undertaking this research.

Through previous clinical experience and contact with ward based practitioners the researcher had always had an awareness of the challenges posed by working in a large organisational system of health care. However, the results of the research highlighted cognitive dissonance between organisational demands and personal and professional

beliefs and values and the effects of these on the nurses' morale and self-esteem. Furthermore, the evidence of lack of a shared philosophy of care amongst practitioners was unexpected and surprising. Both of these results caused the researcher to reflect on the role she currently undertakes in nurse education and areas where this requires changed to assist nurses to challenge and address the organisational issues highlighted.

Particularly interesting to the researcher has been the personal learning gained regarding her interest and relationship with older people and their lives, which enlivened and enlightened the research process.

In relation to the research process itself, much was learnt about the value of undertaking research that focuses on the context and experience of care, and the significance of analysis, discussion and dissemination of findings. The research training that was developed by returning when at all possible, to primary sources during the literature reviewing stage was insightful, as one realised that through using this approach that much of the published literature was less rigorous than it first appeared. In its self this was an immense learning experience. The intensive literature review also allowed the researcher to establish that there were three key moments in the development of the concept of caring in nursing identified through Morse, Solberg et al (1990), Paley (2001) and Brilowski and Wendler (2005) with much written between these dates and nothing further following 2005.

In relation to the actual processes of undertaking research, the frustrations and highs and lows involved in such a concentrated piece of work and the learning experience of

gaining the skills of managing on-going work, personal learning, maintaining a personal life and carrying out research activities has been immense and has contributed to the satisfaction gained by undertaking this research.

The researcher has learnt that although she has moved from nursing practice to nursing education, fundamentally she remains true to her personal and professional values and beliefs in relation to older people and their care.

No research project should stand in isolation, and therefore, the researcher intends to disseminate her findings in several ways. An executive summary will be offered to the participating NHS Trust, and representatives of the professional body to challenge and raise awareness of the issues that emerged from the study. Further it is intended to develop several research papers based on the findings for publication in nursing journals with abstracts submitted to relevant national and international conferences, for scrutiny and selection for presentation.

### **Contribution to nursing and organisational knowledge.**

The research allowed differing perspectives of the patient and nurses in relation to the care experience to be brought together and reviewed. By gaining a total view of the experience of care using explanations of similar situations from two differing perspectives, knowledge of the impact of the organisational context on the care experience of older people can be developed.

New knowledge emerged from this data that showed that older people used knowledge gained from the media regarding poor episodes of care, along with their own previous knowledge of care prior to the NHS, to define their acute care experience. This resulted in an overall positive, generalised and non-critical evaluation of their acute care experience.

Other new knowledge was identified through establishing that older people were clearly able to frame their experiences within the context of the demands of the organisation. They accepted the level of care available, which although not always necessarily as good as it could be due to a variety of factors such as lack of information and less than optimal care experiences, was seen as acceptable due to the constraints of the situation. The level of care they received was also defined in relation to other patient's needs with the explanation that they were less ill than others and therefore required less care.

Several aspects of the organisational context of care were clearly seen, by older people and nurses, to impact on the care experience, and these should be addressed. These were lack of continuity of care, new ways of working, relationships with patients and nurses seen as a homogenous group.

The lack of continuity of care caused by 12 hour shifts seemed to affect the older person's experience in terms of the nurse having time to interact with them, and develop some form of rapport. From the nurses perspective the move to 12 hour shift working has destroyed the shared philosophy of care necessary for good team-working. This leads to tension and frustration for the nurses' as individuals who then provide less than optimal care as a means of survival.



The new ways of working demanded by the organisation, through extended role, paperwork and shift patterns has eroded the time available to deliver direct patient care. To address the issues of lack of time, perceived shortages of nurses and paperwork overload identified by older people and nurses, the organisation should redesign the models of care and paperwork used at present to reflect the changed working environment that exists in the current NHS.

Relationships with the patient featured highly in the nurses' results as crucial to achieving negotiated care. Nurse's predominantly focused on the need for a close therapeutic relationship, rather than a therapeutic interaction, with patients. This fits with the beliefs and values of the nurse which are engendered by the educational process undertaken to gain entry to the profession. When unable to attain this relationship due to constraints of the organisation, nurses' become stress and de-motivated and may ultimately leave the profession. The older people and the organisation do not feel this relationship is of great value, due to seeing nurses as a homogenous group. It is recommended that the organisation becomes a 'corporate' caring organisation which values the nurse's as individuals rather than seeing them as a homogeneous interchangeable group who deliver the same care. Further it is incumbent on education and the profession to refocus the emphasis of caring away from therapeutic relationships to that of a therapeutic interaction with patients.

Several areas for further research emerged, to allow greater understanding of the patient experience. Firstly, research is required into whether the patient desires a one to one

relationship with a named nurse as propounded by the government. Participants in this research did not see it as important to their care experience.

Secondly the effect that the relationship might have on patient recovery requires exploration. Linked to this is a need for research into the patient's expectations and views of nurses as a homogenous group rather than nurse's as individuals. This would allow a more realistic planning of the care experience and reduce the tensions inherent in the current organisational system.

Finally research into the effect the media has on a patient's expectations and experiences of care will establish the effects of media coverage on the level of patient's complaints to the NHS.

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Diagram from Morse Solberg et al (1990) page 3.

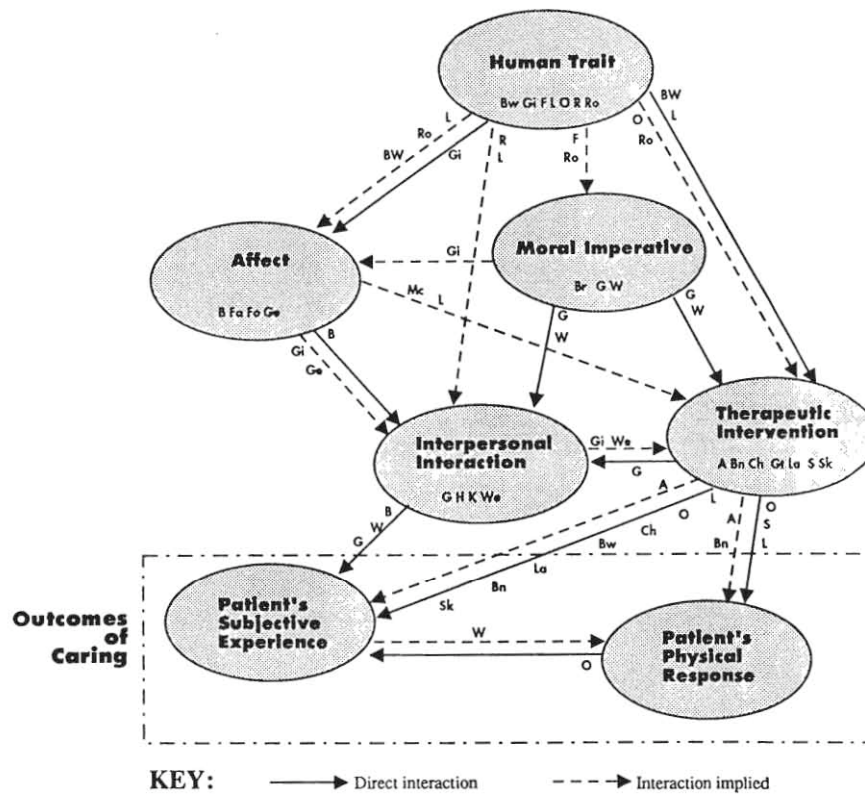


Fig 1. The interrelationship of five perspectives of caring.

A = Aamodt	GW = Gardner and Wheeler
B = Bevis	H = Homer
Bn = Brown	K = Knowlden
Br = Brody	L = Leininger
BW = Benner and Wrubel	La = Larson
CH = Cronin and Harrison	Mc = McFarlane
F = Fry	O = Orem
Fa = Fanslow	R = Ray
Fo = Forrest	Ro = Roach
G = Gadow	S = Stevenson
Ge = Gendron	Sk = Swanson-Kauffman
Gi = Griffin	W = Watson
Gt = Gaut	We = Weiss

## Understanding Care Of Older People In Acute Care Settings

Patient Interview Schedule  
Version 3



Queen Margaret University College  
EDINBURGH

### Interview Schedule

Thank you for agreeing to meet with me and talk about your stay in hospital. I am interested in finding out about what you think care is and the sort of care you received in hospital. There are no right and wrong answers to this, I'd just like to get your views and ideas about what happened while you were in hospital. It would be very helpful if you wanted to give me examples of what happened.

Perhaps we could start with the first part of your stay – the settling in phase when you first arrived.

1. What were your first impressions about the care when you first arrived on the ward?
2. How did you feel you were cared for?
3. What were you expecting?
4. Could it have been different? In what way, do you think?
5. Were you able to be involved in what happened? – dependent on answer follow up with : would you have liked to be involved? Or would you prefer not to be involved?
6. Can you tell me why?

Moving on now to the period of your stay that involved treatment –

7. What sort of care you did you receive?  
How did that make you feel?  
Could it have been done differently?
8. Were you able to be involved in the care?  
Was that a good or a bad thing?  
Why? - consequences
9. Did you feel able to negotiate, or make decisions, about the care you received?  
Would that have been a helpful thing for you?  
Were there some nurses you felt more able to negotiate with about your care?  
Why was that?

Did you feel that your views/decisions were taken into account?

Once you had recovered and were getting ready for being discharged –

10. Did the care you received change in any way?

In what way?

How did that make you feel?

Could it have been done differently?

Were you able to make decisions and negotiate about the care?

11. What qualities do you think make a nurse the most caring nurse.

Why, what was it that made them different?

### **Prompts**

A. Try to imagine a typical morning/afternoon/evening/night, during that period

....

what sort of things happened?

B. Can you give me an example of what happened that made you feel that way?

C. Getting back to your experiences of the nurses and the care.....

D. Are there any particular experiences that stand out during that time?

E. What about other things the nurses did?

F. There's no right or wrong answers, I'd just like to get you thinking about things

### **Probes**

A. What was that like?

B. What happened then...?

C. Go on...

D. Is there anything else?

E. How did that make you feel?

F. How was that helpful?

G. How do you mean?

H. Tell me more.

I. Why do you think that happened?

J. Was that what you expected?

K. Are there any other reasons?

L. What did that mean to you at the time?

M. What were you thinking then?

## Understanding Care Of Older People In Acute Care Settings

Nurse Interview Schedule  
Version 3



Queen Margaret University College  
EDINBURGH

Questions for semi-structured interview.

Thank you for agreeing to have this meeting with me. I am interested in finding out and exploring with you, your ideas about care, what it is, and what sorts of caring you do. There are no right or wrong answers, I'd just like to get you thinking about things that you do in your work.

1. Perhaps we could start with you telling me what caring means to you? –  
And in relation to the work you do in the ward?
2. What do you think are the important aspects of the caring that you do?
3. Do you think this is the same for all people, including staff or are there individual differences?  
What might be the cause of those differences?
4. Are there aspects of your work, that you feel, allow /do not allow you to do the job the way you feel/think it should be done?  
Does that cause you any difficulties?  
Would you do things differently?
5. Looking back over the last few weeks, what situations can you remember that you felt were either good or bad practice in relation to the care you were giving? -  
Did you have the opportunity to follow that up through discussion or supervision?
6. Can you tell me a little about how you feel about caring for older people (those over age of 65) in the ward? –  
What sort of relationship do you have with them?  
Are there any reasons for that?  
Who should be the person that develops and maintains that relationship?
7. Do you positively encourage patients to have a negotiated relationship of care?  
How do you go about doing that?

Do all patients want the same type of care?  
What if you don't agree with the patient's views, or requests?  
Does that affect the way you care for the patient?  
Why do you think they behave in the way they do?  
What sort of patient care planning approaches do you use –  
individualised, standardised, patient centred?

8. Thinking about the environment/ area you work in, starting with the ward, do you think it affects the way you approach your work as a nurse?  
What about the clinical directorate, how does it affect your work?  
How about the organisation as a whole, can it affect your ability to care?

### **Prompts**

- G. Can you give me an example of what happened that made you feel that way?  
H. Getting back to your experiences of the patients and the care.....  
I. Are there any particular experiences that stand out during that time?  
J. What about other things that happened?  
K. Have you tried to challenge that?

### **Probes**

- N. What was that like?  
O. What happened then...?  
P. Go on...  
Q. Is there anything else?  
R. How did that make you feel?  
S. How was that helpful?  
T. How do you mean?  
U. Tell me more.  
V. Why do you think that happened?  
W. Was that what you expected?  
X. Are there any other reasons?  
Y. What did that mean to you at the time?  
Z. What were you thinking then?

## Appendix D

Lindesay M C Irvine  
Course Leader/Lecturer  
Nursing  
School of Health Sciences  
Lirvine@qmuc.ac.uk

Dr H Cubie  
Director of Research  
Lothian University Hospital Trust

27.11.03

Dear Dr Cubie

I am currently a lecturer in Nursing at Queen Margaret University College in Edinburgh. I am studying, on a part-time basis, for a PhD, with my supervisory team of Prof. Alan Gilloran and Ms Doreen MacWhannell. I also have a nurse advisor who is Dr Joanne Booth, Nurse Consultant (Older people) from Forth Valley Primary Care Trust. The title of my proposed research is 'Understanding the social construction of care of older people in acute health settings. I enclose a copy of my research proposal for your information.

My studies are now at a stage where I require to negotiate access to a sample population – in this case, older people who have recently experienced acute in-patient care, and nurses who work in acute care settings. Together with my supervisors I have identified Lothian University Hospital Trust as my preferred research site as the Trust offers a wide range of acute care settings and cares for a diverse patient population. I would be most grateful if you could indicate whether it would be possible for me to use LUHT as a research site, and if so, who would be the most appropriate person or persons to contact regarding negotiating access to an appropriate sample.

I shall be applying to the Lothian Research Ethics Committee for ethical approval for this research study, and feel it would be helpful if I was able to indicate to the committee that there was agreement in principle for access to a sample site.

I look forward to hearing from you

Yours Sincerely

Lindesay M C Irvine  
BA, MSc, RGN, RNT



## Appendix E

Lindesay M C Irvine  
Course Leader/Lecturer  
Nursing  
School of Health Sciences  
[lirvine@qmuc.ac.uk](mailto:lirvine@qmuc.ac.uk)  
12.01.04

Dr H Cubie  
Director of Research  
Lothian University Hospital Trust  
Royal Infirmary of Edinburgh  
51 Little France Crescent  
Old Dalkeith Road  
Edinburgh  
EH16 4SU

Dear Dr Cubie

Following my telephone conversation with your secretary regarding my first letter to you of 27.11.03, I enclose another copy for your perusal and decision regarding access to a sample population in Lothian University Hospital Trust.

With many thanks

Yours Sincerely

Lindesay M C Irvine

## Appendix F

Lindesay M C Irvine  
Course Leader/Lecturer  
Nursing  
School of Health Sciences  
[lirvine@qmuc.ac.uk](mailto:lirvine@qmuc.ac.uk)  
07.04.04

Ms Catriona Rostron  
Principal Nurse for Surgery  
Lothian Health – Acute Hospitals Division  
Western General Hospital  
Crewe Road South  
Edinburgh  
EH 4

Dear Ms Rostron

I am currently undertaking PhD studies at Queen Margaret University College, the research study being entitled ‘Understanding the social construction of care of older people in acute health settings’. Following discussion with Juliet McArthur, Senior nurse – research, I am writing to ask permission to undertake some of my data collection in surgical wards, preferably on the WGH/RVH site. This will entail interviewing 10 qualified nurses, and 10 older (age 65 plus) patients post discharge. The nurse interviews should last about 1 hour and can be undertaken, either during the nurses’ duty hours, or should they prefer it, when they are off duty. I would hope to conduct the interviews in a convenient location for the nurses such as the Wellcome Foundation research unit. The patients will be interviewed approximately 6 weeks post-discharge either in their own homes or at an agreed place. In order to recruit the patients I require to be able to approach them just prior to discharge and this will require discussion with the relevant ward staff regarding ways of identifying patients and gaining access to them. The general focus of the research is to find out about how patients construct their experiences of acute care. It is hoped that the results will allow issues such as the patients’ expectations of care to be understood in greater depth, thus allowing the care they receive to better reflect the patients’ expectations, with the potential benefit of reducing

patient complaints and length of hospital stay. Nursing staff will be interviewed to establish their understanding of their role and experiences of delivering care within the organisational structures of the NHS. There may also be issues identified through this that relate to retention and recruitment of nursing staff.

The study was reviewed by Lothian Ethics committee and subject to minor amendments was approved.

I have still to gain management agreement for the research to take place and I understand this will require your signature on the Management Approval Form prior to submission.

I will be happy to meet with you to discuss the study further, and will certainly send you details of the results on completion of the study. I shall contact you by telephone to allow arrangement of a mutually suitable time to meet. Should you wish to contact me my e-mail address is [lirvine@qmuc.ac.uk](mailto:lirvine@qmuc.ac.uk). I look forward to meeting with you soon.

Yours Sincerely

Lindesay M C Irvine

**Response from Primary Care Trust**

-----Original Message-----

From: Rhona Hogg, Nursing Studies [mailto:rhogg@afb1.ssc.ed.ac.uk]

Sent: 22 April 2004 13:50

To: Irvine, Lindesay

Subject: Re: Advice re PhD

Lindesay,

Your study sounds interesting.

You don't need any management approval for this from LPCT, the acute division is enough.

Rhona

> Rhona

> I am currently registered with QMUC for PhD studies and am negotiating

> the intricacies of LUHT Rand D management approval. They have

> indicated i need to speak to someone in the primary care sector to

> find out if I also need to get LPCT approval. The reason they have

> suggested this is that I am examining older people's perceptions of

> their care in acute care sector and will recruit the sample whilst

> they are in-patients and then will interview them 3- 6 weeks post

> discharge. The GP's will be sent letters informing them of the study

> but they do not have to be involved in any way. There is no nurse

> involvement in the study. Do you think I need to ask LPCT for

> management approval as well as LUHT.

>

> Many thanks for your views

>

> Lindesay

>

> Lindesay M C Irvine

> Course Leader/Lecturer

> BSc(Hons) Nursing

> Queen Margaret University College

> Edinburgh

> EH12 8TS

> [lirvine@qmuc.ac.uk](mailto:lirvine@qmuc.ac.uk)

Dr Rhona Hogg - Community Nursing Research Facilitator School of Nursing  
Studies, University of Edinburgh,

31 Buccleuch Place, Edinburgh EH8 9JS

Tel: 0131 650 3898

## Letter from ethics committee

Lothian NHS Board

Ms Lindesay M C Irvine  
Nursing, School of Health Science  
Queen Margaret University College  
Clerwood Campus  
Edinburgh, EH12 8TS

Lothian Research Ethics Committee  
Deaconess House  
148 Pleasance  
Edinburgh  
EH8 9RS  
Telephone 0131 536 9000  
Fax 0131 536 9346  
[www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)



Date 09 February 2004  
Your Ref  
Our Ref **LREC/2004/4/10**

Enquiries to Dale Keir  
Extension 89025  
Direct Line 0131 536 9025  
Email [dale.keir.scot.nhs.uk](mailto:dale.keir.scot.nhs.uk)

Dear Ms Irvine,

### UNDERSTANDING THE SOCIAL CONSTRUCTION OF CARE OF OLDER PEOPLE IN ACUTE HEALTH CARE SETTINGS.

Thank you for submitting the above research proposal, processed today, 09 February 2004, for ethical review. The Medicine/Clinical Oncology I Research Ethics Committee will consider this protocol at its next meeting to be held on Wednesday 3 March 2004 at 5.15 p.m. in Deaconess House (address as above). There is an opportunity for you to make yourself available to answer any questions at the Committee's discretion but there is no guarantee that you will be required. **You should let the Committee Administrator know in advance if you intend to avail yourself of this opportunity.**

I will notify you of the outcome of this consideration as soon as possible. . Please note that the LREC reference number LREC/2004/4/10 **must** be quoted on all correspondence. Correspondence received without the LREC reference number will be returned.

Details of the Lothian Research Ethics Committee and its documentation can be found on [http://www.nhslothian.scot.nhs.uk/nhs\\_lothian/about\\_lothian\\_health/lrec/index.html](http://www.nhslothian.scot.nhs.uk/nhs_lothian/about_lothian_health/lrec/index.html)

Under the terms of the Scottish Executive Health Department Research Governance Framework for Health and Community Care a copy of the application has been sent to the Research & Development Office of the relevant NHS Trust(s) where the research is intended to take place. It is the NHS Trust(s) from whom you must obtain management approval before any work on the study can proceed.



Headquarters  
Deaconess House 148 Pleasance Edinburgh EH8 9RS

Chair Brian Cavanagh  
Chief Executive James Barbour O.B.E.  
*Lothian NHS Board is the common name of Lothian Health Board*

Yours sincerely

A handwritten signature in black ink, appearing to read 'Dale Keir', with a stylized, cursive script.

**DALE KEIR**  
**Committee Administrator**

*cc*      *None*

## Appendix I

Lindesay M C Irvine  
Course Leader/Lecturer  
Nursing  
School of Health Sciences  
[lirvine@qmuc.ac.uk](mailto:lirvine@qmuc.ac.uk)  
03.04.04

Liz Harden  
Lothian Research Ethics Committee  
Deaconess House  
148 Pleasance  
Edinburgh  
EH8 9RS

Dear Ms Harden

REF: LREC/2004/4/10

Understanding the Social Construction of Care of Older People in Acute Health care Settings

Please find enclosed the revisions to the above research protocol as requested by the Medicine/Clinical Oncology1 Research Ethics Committee.

Point 1. The number of subjects to be recruited is 20 patients and 20 nurses, not 30 as indicated on the form. **New pages 6, 7 and 8 are enclosed.**

Point 2 – following the committees comment interviews with patients will now take place between 3 and 6 weeks discharge. **New page 6 enclosed**

Point 3 – I take note of the committees comment re a control group.

Point 4 – A letter will be sent to all participating patient's GPs, indicating their inclusion in the study and giving information about the study. Draft letter enclosed.

Point 5 – see justification inserted at question 22. **New page 10 enclosed.**

Point 6,7,10,11,13,14 (patient information sheet) – it has been made explicit in the patient information sheet that I am not checking up on individual nurses' professional practice. I have included a statement regarding patient complaints; I have rephrased the first sentence of the paragraph under The purpose of the study, added the details of the local advisor and deleted the penultimate sentence. I have included a statement regarding

destruction of the tapes at the end of the study. **New patient information sheet enclosed.**

Point 8 – I have reviewed the consultant letter and have noted your advice.

Point 9 – The non-participant reply form has been removed.

Point 10, 11, 13 – the nurses information sheet has been amended. I have rephrased the first sentence of the paragraph under ‘The purpose of the study’, added the details of the local advisor and deleted the penultimate sentence. I have included a statement regarding destruction of the tapes at the end of the study. **New nurse information sheet enclosed.**

Point 12 – If my interviews elicit any information of a serious or litigious nature I will advise the person of their responsibility to take appropriate action through the hospital complaints procedure (if appropriate). I will discuss the situation with my PhD supervisors and would advise the clinical nurse manager, with responsibility for the area of the situation.

Point 14 and 15 - Questions 11 and 2 of the patient interview schedule have been rephrased, as has question 4 of the nurses interview schedule. **New interview schedules enclosed.**

I hope the changes meet with the committee’s approval.

With many thanks

Yours Sincerely

Lindesay M C Irvine



Lothian NHS Board

Lothian Research Ethics Committee  
Deaconess House  
148 Pleasance  
Edinburgh  
EH8 9RS  
Telephone 0131 536 9000  
Fax 0131 536 9346  
[www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)



Ms Lindesay M C Irvine  
Nursing, School of Health Science  
Queen Margaret University College  
Clerwood Campus  
Edinburgh, EH12 8TS

Date 10 May 2004  
Your Ref  
Our Ref LREC/2004/4/10  
Enquiries to Dale Keir  
Extension 89025  
Direct Line 0131 536 9025  
Email [dale.keir@lhb.scot.nhs.uk](mailto:dale.keir@lhb.scot.nhs.uk)

Dear Ms Irvine,

### UNDERSTANDING THE SOCIAL CONSTRUCTION OF CARE OF OLDER PEOPLE IN ACUTE HEALTH CARE SETTINGS.

Thank you for submitting the changes requested in respect of the above research proposal for ethical review. Acting with the Medicine/Clinical Oncology I Research Ethics Committee of the Lothian Research Ethics Committee's delegated authority I can confirm that these changes address the issues raised and that the conditions set by the Committee for a favourable ethical opinion have been met. An official Certificate of Ethical Opinion outlining the conditions of this opinion is enclosed together with a list of members present at the meeting. **Please note that the LREC reference number LREC/2004/4/10 must be quoted on all correspondence. Correspondence received without the LREC reference number will be returned.**

Under the terms of the Scottish Executive Health Department Research Governance Framework for Health and Community Care this opinion has been notified to the Research & Development Office of the relevant NHS Trust(s) where the research is intended to take place. It is the NHS Trust(s) from whom you must obtain management approval before any work on the proposed research can proceed.

Details of the Lothian Research Ethics Committee and its documentation can be found on [http://www.nhslothian.scot.nhs.uk/nhs\\_lothian/about\\_lothian\\_health/lrec/index.html](http://www.nhslothian.scot.nhs.uk/nhs_lothian/about_lothian_health/lrec/index.html)

Yours sincerely

DALE KEIR  
Committee Administrator



Headquarters  
Deaconess House 148 Pleasance Edinburgh EH8 9RS

Chair Brian Cavanagh  
Chief Executive James Barbour O.B.E.  
*Lothian NHS Board is the common name of Lothian Health Board*

LOTHIAN RESEARCH ETHICS COMMITTEE

CERTIFICATE OF ETHICAL OPINION

LREC Reference Number: LREC/2004/4/10

Title: Understanding the Social Construction of Care of Older People in Acute Health Care Settings

Researcher: Ms Lindesay M C Irvine

The Medicine/Clinical Oncology I Research Ethics Committee of the Lothian Research Ethics Committee (the Committee) reviewed this proposed research and is of the opinion that it is ethical and appropriate to be carried out in the Lothian Area. This opinion encompasses all aspects of the application including the Patient/Subject Information Sheet and all other accompanying documentation provided.

The LREC application form, protocol, subject information sheet, information on compensation arrangements, payments to researchers and the provision of expenses to subjects (where appropriate) were reviewed and approved and the members of the Committee present at the meeting are shown on the attached *Membership List*.

This opinion is issued subject to the following conditions and is invalid if they are not followed:

- You must obtain appropriate management approval from the relevant NHS Trust(s) before starting the proposed research. It is the NHS Trust(s) that ultimately decide whether or not this research should go ahead taking account of the advice of the Local Research Ethics Committee.
- You must notify the Sub-Committee and the relevant NHS Trust(s), in advance, of any significant proposed deviation from the original protocol or application form and obtain approval for any such amendments using the *Amendment Approval Request Form*.
- You must submit reports to the Sub-Committee and the NHS Trust(s) once the study is underway if there are any unusual or unexpected results which raise questions about the safety of the research.
- You must report annually on successes, or difficulties, in recruiting subjects in order to provide useful feedback on perceptions of the study among patients and volunteers using the *Progress Report Form*.
- Where the study is terminated prematurely you must report within fifteen days indicating the reasons for early termination.
- You must submit a final report within three months of the completion of the study using the *Progress Report Form*.



Peter Reith  
Secretary  
Lothian Research Ethics Committee

10 May 2004



Dale Keir  
Administrator  
Medicine/Clinical Oncology I  
Research Ethics Committee

**Nurse Coding List**

NURSES APPROACHES TO CARE WORK	NRCW
NRCW: personal view of important	NRCW – PV
NRCW: professional aspects	NRCW – PA
NRCW: differences in care approach	NRCW – DCA
NRCW: hindrances	NRCW – H
NRCW : helping aspects	NRCW – HA
NRCW : good practice	NRCW – GP
NRCW : poor practice	NRCW – PP
NRCW : follow up system	NRCW – FU
NRCW : holistic	NRCW – HO
NRCW : just a job	NRCW – JJ
NRCW : troubleshooting	NRCW - T
NURSE RELATIONSHIP WITH PATIENT	NRRel
NRRel: minimal	NRRel – M
NRRel: strong	NRRel – S
NRRel: maintained by	NRRel – MB
NRRel: relatives needs	NRRel – RN
NRRel: care related	NRRel - C
NURSE AND NEGOTIATED RELATIONSHIP OF CARE	NRNRel
NRNRel: able to negotiate	NRNRel – Neg
NRNRel: patient choice/individual	NRNRel – PC/I
NRNRel:disagreement	NRNRel – D
NRNRel: affect on care	NRNRel – AC
NRNRel: care planning approach	NRNRel – CPA
NRNRel: patient decision making	NRNRel – DM
NURSES VIEWS; IMPORTANT CARE	NRVIC
NRVIC: physical care	NRVIC – PC
NRVIC: emotional care	NRVIC – EM
NRVIC: all together	NRVIC - ALL
NURSES WORK AND	NRWO

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**ORGANISATIONAL DECISIONS**

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NRWO: personal effect	NRWO – PE
NRWO: involved	NRWO – I
NRWO : not involved	NRWO – NI
NRWO: positive effect on care	NRWO – PC
NRWO ; negative effect on care	NRWO – NC
NRWO: Nurses role primary	NRWO - NR <sup>5</sup>
NRWO: paperwork/audit	NRWO - PW

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**NURSES AS INDIVIDUALS**

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**NRI**

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NRI: known as individuals	NRI – KI
NRI: treated as valued	NRI – TV
NRI: ignored	NRI – I
NRI: depersonalised	NRI – DP
NRI: not valued	NRI – NV
NRI: devolved responsibility	NRI - DR
NURSES VIEW OF CARE	NRCE
ENVIRONMENT	

NRCE: design positive	NRCE – P
NRCE: design negative	NRCE – N
NRCE: nurse accessibility	NRCE - NA

---

**NURSES WORK AND  
ORGANISATIONAL DEMANDS**

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**NRWOD<sup>6</sup>**

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NRWOD: affect care negative	NRWOD– NAC
NRWOD: affect care positive	NRWOD – PAC
NRWOD: nurses role primary	NRWOD – NR
NRWOD: paperwork/audit	NRWOD – PW

---

<sup>5</sup> Following coding it was decided that the final code set of NRWOD was categorising very similar things to those of NRWO as it was difficult to establish when an organisation decision was not also an organisation demand. Therefore NRWO had two new categories within it, that of NR and PW, the other two were subsumed in PC and NC.

<sup>6</sup> Following coding it was decided that the final code set of NRWOD was categorising very similar things to those of NRWO as it was difficult to establish when an organisation decision was not also an organisation demand. Therefore NRWO had two new categories within it, that of NR and PW, the other two were subsumed in PC and NC.

## Patient Coding List

PATIENT RESPONSE TO SITUATION	PtRESP
PtRESP: critical of culture	PtRESP -CCult
PtRESP: non-caring	PtRESP -NC
PtRESP: critical of care	PtRESP - CCare
PtRESP: self-determined care	PtRESP- SDCare
PtRESP: surprise	PtRESP - Surp
PtRESP: self-critical	PtRESP - SC
PtRESP : justification of care	PtRESP - JC
PtRESP: uncritical acceptance	PtRESP - UA
PtRESP: relationship with nurse	PtRESP- RelN
PtRESP: play the role/acceptance	PtRESP - RA
<b>POSITIVE EXPERIENCES</b>	<b>PE</b>
PE: physical environment	PE - PE
PE: nurse availability	PE -NA
PE: given choice	PE -Ch
PE: decision making	PE - DM
PE: gained information	PE -Info
PE: patient centred care	PE -PCC
PE: involvement in care	PE -IIC
PE: named nurse/same nurse	PE -NN
PE: relationship positive	PE - RelP
PE: negotiation	PE -Neg
PE: nurse contact	PE -NC
PE: compassion/care	PE - CC
<b>NEGATIVE EXPERIENCES</b>	<b>NE</b>
NE: physical environment	NE – PE
NE: treatment	NE – T
NE: information lack	NE – Info
NE: non facilitative care	NE – NFC
NE: non relationship	NE - NR
NE: lack continuity of care	NE – LCC
NE: decision making	NE – DM
NE: intrusive care	NE – IC
NE: nurse contact lack	NE – NC
NE: non patient centred	NE – NPC
NE: no named nurse	NE – NNN
NE: non qualified nurse	NE – NQN
NE: no choice	NE - NCh
<b>PATIENT RESPONSES TO OTHER PATIENTS</b>	<b>PtPt</b>
PtPt: accepting	PtPt – A
PtPt: critical	PtPt – C
PtPt: ideas of attitude/context	PtPt – IAC
PtPt: distressing/upsetting	PtPt – DU
PtPt: assisting others	PtPt - ASS









